

No. 88-1377

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Supreme Court of the United States
FILED
MAY 10 1989
JOSEPH F. SPANGL, JR.

In the Supreme Court of the United States

OCTOBER TERM, 1988

LOUIS W. SULLIVAN, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER

v.

BRIAN ZEBLEY, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

JOINT APPENDIX

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PETITION FOR A WRIT OF CERTIORARI
FILED: FEBRUARY 15, 1989
CERTIORARI GRANTED: MAY 15, 1989

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UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

No. 83-3314

ZEBLEY, BRIAN, BY HIS PARENT AND NATURAL GUARDIAN,
ZEBLEY, JOHN, ON BEHALF OF HIMSELF AND ON BEHALF OF A
CLASS ALL OTHER SIMILARLY SITUATED

INTERVENOR: RAUSHI, EVELYN, BY HER PARENT AND
NATURAL GUARDIAN, RAUSHI, MARY

INTERVENOR: (4) LOVE, JOSEPH, JR., BY HIS PARENT AND
NATURAL GUARDIAN, MARGARITE LOVE

v.

MARGARET HECKLER, SECRETARY OF HEALTH AND HUMAN
SERVICES

RELEVANT DOCKET ENTRIES

Date	NR	Proceedings
<i>1983</i>		
July 12	1	Complaint, filed.
July 12	1	Summons exit.
July 12	2	MOTION AND ORDER APPOINTING MICHAEL DONAHUE TO SERVE COMPLAINT AND SUMMONS ON DEFT., FILED. 7/12/83 copy with summons given to counsel.
July 14	3	Return of service of summons and complaint with affidavit of M. Kaufman re: served deft on 7-12-83, filed.
Sept. 2	4	MOTION TO INTERVENE, BRIEF

Date	NR	Proceedings
		IN SUPPORT, NOTICE, FILED. (Complaint of Intervenor attached).
Sept. 9	5	Answer, filed.
Sept. 9	5	Issue joined.
Oct. 6	6	Gov't response to request for admissions, filed.
Oct 13	6	PLFF-INTERVENOR JOSPEH LOVE, JR.'S MOTION FOR CLASS CERTIFICATION, MEMORANDUM OF LAW, CERTIFICATE OF SERVICE, FILED.
Oct. 18	8	STIPULATION & ORDER EXTENDING DEFTS TIME TO RESPOND TO PLFF'S MOTION TO INTERVENE TO 10-15-83, FILED. 10/18/83 entered & copies mailed. JF
Oct. 28	8	STIPULATION & ORDER EXTENDING DEFT'S TIME TO RESPOND TO PLFF'S MOTION FOR CLASS CERTIFICATION TO 11-25-83, FILED. 10/28/83 entered & copies mailed. JF
Nov. 1	10	EVELYN RAUSHI's MOTION TO INTERVENE, MEMORANDUM OF LAW, NOTICE, FILED. (COMPLAINT ATTACHED).
Dec. 14	11	Gov't opposition to motion for class certification, filed.
Dec. 20	12	STIPULATION & ORDER EXTENDING DEFT'S TIME TO RESPOND TO PLFF'S MOTION FOR CLASS ACTION CERTIFICA-

Date	NR	Proceedings
		TION TO 12-9-83, FILED. 12/20/83 entered & copies mailed. JF
Dec. 22	13	Plff's response to defts opposition to motion for class certification, filed.
1984		
Jan. 11	14	ORDER THAT PLFFS' MOTION FOR CLASS CERTIFICATION IS GRANTED & THIS ACTION MAY BE MAINTAINED AS A CLASS ACTION, ETC., FILED. 1/11/84 entered & copies mailed. JF
Mar. 26	15	GOVT'S MOTION FOR REMAND, MEMORANDUM OF LAW, NOTICE, CERTIFICATE OF SERVICE, FILED.
Apr. 6	16	Potential intervenor, Evelyn Raushi's memorandum in opposition to Govt's motion to remand, filed.
Apr. 26	17	Answer, filed.
Apr. 26	17	Issue joined.
June 18	18	JOINT MOTION TO AMEND THE ORDER SETTING 6-18-84 AS THE DATE FOR COMPLETION OF DISCOVERY & 6-18-84 AS THE DATE THE CASE WILL BE READY FOR TRIAL, BRIEF IN SUPPORT, CERTIFICATE OF SERVICE, FILED.
June 22	18	ORDER THAT MOTION TO AMEND THE ORDER OF 3-12-84 IS GRANTED. THE PARTIES SHALL HAVE UNTIL 9-18-84 TO COMPLETE DISCOVERY & THE

Date	NR	Proceedings
		MATTER SHALL BE LISTED FOR TRIAL ON 10-1-84, FILED. 6/22/84 entered & copies mailed. JF
June 28	18	PLFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT, BRIEF IN SUPPORT, CERTIFICATE OF SERVICE, FILED.
July 18	18	GOVT'S MOTION FOR SUMMARY JUDGMENT, BRIEF IN SUPPORT, CERTIFICATE OF SERVICE, FILED.
Sept. 27	20	PLFF'S MOTION FOR ORDER COMPELLING DISCOVERY OR FOR SANCTIONS, MEMORANDUM OF LAW, NOTICE, CERTIFICATE OF SERVICE, FILED.
Oct. 1	22	Withdrawal of appearance of Margaret L. Hutchinson, AUSA for Margaret Heckler & appearance of Joan K. Garner, AUSA for same, filed.
Oct. 12	23	MEMORANDUM & ORDER THAT DEFT'S MOTION FOR PARTIAL SUMMARY JUDGMENT IS DENIED; PLFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT IS GRANTED. THE CASE IS REMANDED TO THE SECRETARY FOR CALCULATION AND AWARD OF BENEFITS, FILED. JF 10/12/84 entered & copies mailed.

Date	NR	Proceedings
Oct 24	24	Govt's brief in opposition to motion for order compelling discovery or for sanction filed.
1985		
Mar. 11	25	DEFT'S MOTION FOR SUMMARY JUDGMENT, BRIEF, CERTIFICATE OF SERVICE, FILED.
Mar. 11	26	DEFT'S UNCONTESTED MOTION TO REMAND CLAIM OF EVELYN RAUSHI ONLY, PURSUANT TO NEW SOCIAL SECURITY LEGISLATION, CERTIFICATION OF UNCONTESTED MOTION, CERTIFICATE OF SERVICE, FILED.
Mar. 13	26	ORDER THAT CLAIM OF INTERVENOR EVELYN RAUSHI ONLY IS REMANDED TO SECY OF HHS, FILED. 3/14/85 entered & copies mailed.
Mar. 27	27	STIPULATION & ORDER THAT PLFFS HAS UNTIL 4/30/85 TO FILE RESPONSE TO DEFTS MOTION FOR SUMMARY JUDGMENT, FILED. 3/28/85 entered & copies mailed.
Apr. 30	28	Plffs Memorandum of Law in Opposition to Defts Motion for Summary Judgment, Certificate of Service, filed.

Date	NR	Proceedings
Apr. 30	29	Appendicies to Plffs Memorandum of Law, filed.
May 20	30	Defts Reply to Plffs Memorandum of Law in Opposition to Defts Motion for Summary Judgment, cert of serv, filed.
Sept. 18	31	ORDER DTD 12/21/83 THAT LEAVE TO INTERVENE AS PLFFS IS GRANTED, FILED. 9/18/85 entered & copies mailed.
Sept. 18	(4)	Complaint of Intervenor Joseph Love, Jr., filed.
<i>1986</i>		
Mar. 3	32	Deft's Amendment to Brief in Support of Motion for Summary Judgment, Certificate of Service, filed.
July 17	33	MEMORANDUM AND ORDER THAT DEFT'S MOTION FOR SUMMARY JUDGMENT IS GRANTED IN PART THE CLAIMS OF THE PLFF CLASS, CHALLENGING THE SECRETARY'S REGULATIONS REFERRED TO IN THE COMPLAINT ARE DISMISSED WITHOUT PREJUDICE TO THE CLAIMS OF THE NAMED PLFFS INTERVENOR PLFFS AND INDIVIDUAL CLASS MEMBERS, FILED. 7/17/86 entered and copies mailed.

Date	NR	Proceedings
Aug. 7	34	Plff's Notice of Appeal, filed. (86-1518) 8/7/86 copies to: D. Spitz, Clerk USCA, Judge Fullam, J. Garner, AUSA.
Aug. 7	35	Copy of Clerk's Notice to USCA.
Aug. 11	36	Copy of transcript purchase order form, filed.
Aug. 11	36	RECORD COMPLETE FOR PURPOSES OF APPEAL - TRANSCRIPT NOT NEEDED.
Aug. 11	37	Copy of TPO form, filed.
Sept. 10	38	PLFF'S MOTION FOR LEAVE TO PROCEED IN FORMA PAUPERIS, STATEMENT IN SUPPORT THEREOF, FILED.
Oct. 1	39	Certified Copy of Order from U.S.C.A. dated 9/30/86 that the appeal is dismissed filed.
Oct. 10	(38)	ORDER THAT THE PLFFF BE PERMITTED TO PROCEED IN FORMA PAUPERIS WITHOUT PAYMENT OF THE COSTS OF SAID PROCEEDING OR SECURITY THEREFORE, FILED. 10/10/86 entered and copies mailed.
<i>1987</i>		
Mar. 26	40	PLFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT, BRIEF, CERT. OF SERVICE, FILED.
Apr. 7	41	DEFT'S UNAPPOSED MOTION FOR EXTENSION OF TIME TO

Date	NR	Proceedings
		FILE MOTION FOR SUMMARY JUDGMENT, CERT OF SERVICE, FILED.
Apr. 15	42	Stipulation to Remand to Sec. of Health and Human Service, filed.
Apr. 23	42	ORDER THAT THIS MATTER IS REMANDED TO THE SOC. OF HEALTH AND HUMAN SERVICES, ETC., FILED. 4/23/87 ENTERED AND COPIES MAILED.
Jun. 16	43	Plff's Notice of Appeal, filed. (88-3314) 6/16/87 copies to: Clerk, U.S.C.A., D. Spitz, Judge Fullam, Joan K. Garner, AUSA
Jun. 16	44	Copy of Clerk's Notice to U.S.C.A., filed.
July 22	44	RECORD COMPLETE FOR PURPOSES OF APPEAL.
Aug. 4	45	Certified copy of order dated 8/3/87 from U.S.C.A. that Appellee's letter-Motion to dismiss appeal for lack of jurisdiction is granted, etc., filed.
Sep. 3	46	PLFF'S MOTION FOR CERTIFICATION AND ENTRY OF JUDGMENT, MEMO., CERT. OF SERVICE, FILED.
Sep. 14	47	Deft's Response to Motion for Certification and Entry of Final Judgment, Cert. of Service, filed.
Sept. 16	48	Deft's Amended Certificate of Service, filed.

Date	NR	Proceedings
Sept. 25	49	Plff's Reply Memo in Support of Rule 54(b) Certification, Cert. of Service, filed.
Oct. 27	(46)	ORDER THAT THIS COURT HAS DIRECTED THE ENTRY OF FINAL JUDGMENT OF THE CLAIMS OF PLFF & THAT THERE IS NOT JUST REASON FOR DELAY, FILED. 10/29/87 entered & copies mailed
Nov 5	50	Plff's Notice of Appeal, filed (USCA 87-1692). 11/5/87 copies to: M. Kauffman, Esq. J. Garner, Esq., D. Spitz, Clerk, USCA, Judge Fullam
Nov 5	51	Copy of Clerk's Notice to USCA, filed.
Nov 10	52	Copy to TPO form, filed.
Nov 12	52	RECORD COMPLETE FOR PURPOSES OF APPEAL - TRANSCRIPT NOT NEEDED.
1988		
Aug 19	53	Deft's Praecipe to file copy of supplemental transcript, filed.
Oct 27	54	Certified copy of order from USCA that the judgment of this Court entered 4/23/87 as certified final by the order entered 10/29/87 is vacated, in part and the cause is remanded to this Court, etc., filed.
Nov 21	55	PLFF'S MOTION FOR SUMMARY JUDGMENT DIRECTED TO BE ENTERED BY THE THIRD CIRCUIT COURT OF APPEALS, MEMO., CERTIFICATE OF SERVICE, FILED.

Date	NR	Proceedings
Nov. 21	56	DEFT'S MOTION FOR STAY, MEMO., CERTIFICATE OF SERVICE, FILED.
Dec. 5	57	Plff's Memo in Opposition to the Secretary's Motion for a Stay of Proceedings, filed.
Dec. 6	58	Deft's Memo of Points & Authorities in Opposition to Plff's Motion for SUMMARY Judgment, filed.
Dec. 15	59	PLFF'S MOTION FOR REMAND AND PRETRIAL SUMMARY JUDGMENT, MEMO., CERTIFICATE OF SERVICE, FILED.
Dec. 22	60	Deft's reply to Plff's Memo in opposition to the Secretary's Motion for a Stay of Proceedings, Certificate of Service, filed.
Dec. 30	61	Plff's Reply to Deft's Memo of Points & Authorities in Opposition to Plff's Motion and Response to Deft's Memo in Opposition to the Secretary's Motion for a stay of Proceedings and for Summary Judgment, filed.
<i>1989</i>		
Jan. 6	62	Deft's response to Plff's Motion to remand, filed.
Jan. 19	63	Argued Sur: hearing of 1/12/89. Plff's motion for Summary Judgment and Government Motion for Stay, filed.
Jan. 26	64	Argued Sur: hearing of 1/26/89 re: proposed summary judgment Order, C.A.V., filed

Date	NR	Proceedings
Feb. 3	65	Deft's praecipe for filing declaration, filed.
Mar. 27	66	Govt's Information regarding pending legislation in Congress, filed.

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 88-1009

ZEBLEY, BRIAN, BY HIS PARENT AND NATURAL GUARDIAN,
ZEBLEY, JOHN, ON BEHALF OF HIMSELF AND ON BEHALF OF A
CLASS ALL OTHER SIMILARLY SITUATED

INTERVENOR: RAUSHI, EVELYN, BY HER PARENT AND
NATURAL GUARDIAN, RAUSHI, MARY

INTERVENOR: LOVE, JOSEPH, JR., BY HIS PARENT AND
NATURAL GUARDIAN, MARGARITE LOVE

APPELLANTS

v.

OTIS R. BOWEN, M.D., SECRETARY OF HEALTH AND
HUMAN SERVICES

RELEVANT DOCKET ENTRIES

Record, Exhibits & Brief Information/Filing:

11/18/87	Briefing Notice Issued
1/14/88	Brief for <i>Amicus</i> American Academy of Child and Adolescent Psychiatry
1/14/88	Brief for <i>Amicus</i> Pennsylvania Protection and Advocacy, Inc., et al.
1/14/88	Appendix
1/15/88	Brief for <i>Amicus</i> Spina Bifida Associa- tion of Greater Los Angeles
1/15/88	Brief for Appellants

Record, Exhibits & Brief Information/Filing:

1/25/88	Extension of time to file Appellee's Brief—Order Filed: 1/27/88—Exten- sion to: 2/26/88
2/26/88	Brief for Appellee
3/15/88	Reply Brief for Appellants

Summary of Events

ARGUED:	5/3/88
PANEL:	Gibbons, ChJ, Mansmann & Cowen, CJ—
OPINION:	8/10/88—Signed
JUDGMENT:	Vacating in part, affirming in pari (bj)
PET. FOR REHG.:	10/3/88 by Appellee. See 10/3/88 Order P2 Denied In Banc—10/18/88 Judges Seitz & Hutchinson would have granted Rehear- ing In Banc. (bj)
MANDATE ISSUED:	10/26/88
RECORD RETURNED:	10/26/88
CERTIORARI FILED:	2/15/88—S.C. #88-1377

Date	Filings—Proceedings
1987	
Dec. 14	Motion by aplt. for modification of brief- ing schedule, filed. (gt)
Dec. 14	Order (Clerk) denying above motion as presented. Apls. to f&s brief & joint appendix on or before 1-14-88. Aplee. may make its own motion for X if necessary, filed. (gt)

Date	Filings — Proceedings
1988	
Jan. 15	Motion by aplt. for leave to file B in excess of 50 pages, filed. (gt)
Jan. 20	Motion by Spina Bifida Assoc., etc. for leave to file brief of Amici Curiae, filed. (gt)
Jan. 21	Order (Clerk) granting motion to exceed page limit with filing as of date of this order, filed. (gt)
Jan. 28	Order (<i>Sloviter</i> , C.J.) granting above mot to file brief amici curiae by Spina Bifida Assoc. of Greater L.A., in light of the representation made that cnsl for apees has no objection to filing of a brief amici curiae, filed. (adl)
Mar. 7	Letter dd. 2-26-88 from Peter Krynski, Esq., cnsl for appee, rec'd for the info of the Ct.
Mar. 15	Motion of aplt's for leave to file RB one day OT & for additional pagination filed. (gt) SEND TO MERITS PANEL
Mar. 18	Order (Clerk) referring above motion to merits panel, filed. (gt) SEND TO MERITS PANEL
Mar. 25	Let. ddt. 3-21-88 from aplee. sent pur. Rule 28(j) of F.R.A.P., filed. (gt)
Mar. 22	Order (<i>Gibbons</i> , Mansmann and Cowen) granting aplt's. mot. to file R.B. one day OT and for add'l. pagination, filed. (gt)
Apr. 7	Letter dd 4/6/88 pur. 28(j), F.R.A.P., rec'd. from Jonathan M. Stein, Esq., cnsl for appellants, rec'd for info of Ct. (gt) SEND TO MERITS PANEL

Date	Filings — Proceedings
May 23	Let. ddt. 5-12-88 from Peter J. Krynski, Esq., sent pursuant to Rule 28(j) F.R.A.P., filed. (gt)
June 1	Letter dd. 5/31/88 from Jonathan M. Stein, Esq., cnsl for aplt's, pur. to Rule 28(j), F.R.A.P., filed. (gb)
June 6	Let. from aplee. ddt. 6-1-88, sent pursuant to Rule 28(j), filed. (gt)
Aug. 16	Motion for Enlargement of Time to Seek Rehearing & Rehearing in Banc, by Aplee, O. Bowen, to & Incl. Sept. 23, 1988, w/serv., fld. (bj)
Aug. 17	ORDER (Clerk) granting above motion to & incl Sept. 23, 1988, fld. (bj)
Aug. 19	Ltr dtd 8-17-88 frm M.A. Kaufman, Esq., rec'd (bj)
Sept. 27	Motion For Leave To File Petition For Rehng & Suggestion For Rehng in Banc with Two Additional Opinions Attached as Part of Exhibit Required by Local Rule 22.1, by the Appellee, w/serv., fld. (bj)
Oct. 3	Order (Mansmann, C.J.) granting the above motion, fld. (bj)
1989	
Jan. 12	Ltr dtd 1-9-89 frm Clk of U.S. Supreme Ct. advising this Ct. that on 1-9-89 and Order was filed extending the time to & including Feb. 15, 1989 w/in which to file a pet. for writ of Cert., rec'd (bj)

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 83-3314

BRIAN ZEBLEY, BY HIS PARENT AND NATURAL GUARDIAN,
JOHN ZEBLEY 106 WASHBURN STREET, UPLAND,
PENNSYLVANIA ON BEHALF OF HIMSELF AND ON BEHALF OF A
CLASS ALL OTHER SIMILARLY SITUATED, PLAINTIFFS

v.

MARGARET HECKLER, SECRETARY OF HEALTH AND HUMAN
SERVICES, DEFENDANTS

CLASS ACTION

COMPLAINT

I. PRELIMINARY STATEMENT

1. This class action arises under provisions of Social Security Act creating Supplemental Security Income disability benefits for poor disabled and blind children, 42 U.S.C. § 1383(c)(3), and is being brought to insure that children's disabilities are adjudged by the Secretary under a comparable scheme to that of adults in conformity with the Act.

2. The gravamen of plaintiffs' claim is that the Secretary of Health and Human Services ["Secretary"] has promulgated regulations and issued instructions to personnel of the regional, district, disability determination divisions, Office of Hearings and Appeals of the Social Security Administration (SSA) whereby children have their entitlement to SSI disability benefits based solely on the grounds that they have a listed impairment or the medical equivalent of a listed impairment 20 C.F.R. § 416.923, in

contravention of the Act's requirement that a child be considered disabled "if he suffers from any medically determinable physical or mental impairment of comparable severity" to that which disables an adult under the program. 42 U.S.C. § 1382(c)(a)(3)(A). The issue, therefore, is the statutory construction of the phrase "comparable severity". The Secretary has established three routes by which an adult may prove disability, known as (1) "listed impairments"; (2) "medical equivalence" and "medical and vocational factors". 20 C.F.R. § 416.901-416.920. The first two categories are narrow and consist solely of medical findings promoting administrative convenience and efficiency by avoiding a need for further evaluation of claimants who meets those criteria. The third route is broader and more flexible and requires consideration of the claimants actual ability to function or perform substantial gainful work. The Secretary has required children, however, to prove disability only by one of the first two routes. Congress intended a single standard for SSI disability and the Secretary has violated that congressional authorization.

Injunctive and declaratory relief is therefore sought to ensure that fundamental principle of constitutional and statutory law and otherwise proper legal standards are used in the determination of disability for children.

II. JURISDICTION

3. Jurisdiction is conferred on this Court by 42 U.S.C. § 405(g) and 42 U.S.C. § 1383(c)(3) which grant jurisdiction to the federal courts to review a final decision of the Secretary with regard to a claim for benefits under the SSI program as plaintiffs have fully presented their claims for benefits to the Secretary and have received a "final decision" of the Secretary within the meaning of the Social

Security Act. These jurisdictional statutes, pursuant to the U.S. Supreme Court interpretation, also provide for appeals which are class actions in the district court.

4. Jurisdiction is also conferred upon federal defendants by 28 U.S.C. § 1361 to compel an officer of the United States to perform his duty.

III. PARTIES

5. Plaintiff, Brian Zebley, by his father and natural guardian, John Zebley, is a resident of Pennsylvania and the County of Delaware claiming benefits under Social Security No. 201-58-0223. Based on an application filed September 12, 1980 Brian M. Zebley was granted Supplemental Security Income benefits pursuant to a finding that he was under a disability as defined in the Social Security Act.

6. Defendant, Margaret Heckler, Secretary of the United States Department of Health and Human Services is statutorily responsible for the administration of the Social Security Administration and payment of disability benefits for disabled children under the Supplemental Security Income Disability Program, 42 U.S.C. § 1381 et seq.

IV. CLASS ACTION ALLEGATIONS

7. The named plaintiff brings this action on his own behalf and pursuant to Rule 23 (a)(b), Federal Rules of Civil Procedure on behalf of all other persons similarly situated. The class is composed of Social Security Income Disability child beneficiaries who have been or are receiving disability benefits or who, but for the unlawful policy of the secretary would be receiving benefits and whose entitlement have been or are now threatened with reduction or cessation because the Secretary determines child dis-

ability under a different scheme than adults in violation of 42 U.S.C. § 1383(c)(a)(3)(A).

8. This class is so numerous that joinder of all persons is impossible and impracticable. It is not possible to determine the precise numbers of individuals affected by the Secretary's policy because the Social Security Administration does not maintain statistics regarding the reasons for cases being denied beyond initial denial level. With respect to initial determination of children's SSI disability claims, in 1978 nationally there were 23,253 denial decisions based on a failure to meet the medical standards specifically applicable to children. In 1979 this national figure was 28,812 and for the first two months of 1980 there were 7,385 such denials.

9. In 1983 as of the first six months of 1983 nationally there were 10,000 such denials. These figures are for all children due SSI blind/disabled benefits at the initial level and do not include termination decisions.

10. There are questions of law and fact common to the entire class which predominate over questions regarding only the named plaintiff. These include, inter alia:

(a) Whether the defendants violate the Social Security Act by violating the "comparable severity" provision of 42 U.S.C. § 1382c(a)(3)(A) by failing to consider factors for children which are comparable to vocational factors for adults in clear contravention of the plain language of the statute and the congressional intent in enacting the program.

(b) Whether the defendant violate the due process clause of the 5th Amendment of the United States Constitution by arbitrarily and capriciously and without authority establishing a separate and more restrictive standard for evaluating a child claimant disability than an adult claimant's disability.

11. The above claims of the named plaintiffs are typical of the claims of the class they represent.

12. Named plaintiffs will fairly and adequately represent and protect the interest of the class they represent. They have the same interest in having applied to them the same legal standards as sought for all child disability claimants. Plaintiff's attorneys have successfully litigated similar class actions and possess the experience and expertise to handle class actions of this type.

13. The defendants have denied or will soon deny plaintiffs and the proposed class their Social Security Act entitlements and due process of law based on policies and regulations of general application of the class.

V. FACTUAL ALLEGATIONS OF NAMED PLAINTIFF

14. Brian Zebley, born July 13, 1978 was from September 12, 1980 to January 26, 1983 a recipient of Supplemental Security Income Disability benefits as a disabled child.

15. Subsequent to the initial determination of disability the S.S.A. determined that the child disability ceased in May, 1982 and that his eligibility for Supplemental Security Income terminated July 31, 1982.

16. Said determination was duly appealed to all levels of administrative review and on May 20, 1983 the Appeals Council entered the final decision of the Secretary finding that Brian Zebley's disability had ceased, copy attached Appendix "A". The decision of the Appeals Council incorporated by reference the decision of the Administrative Law Judge on January 26, 1983, copy attached as Appendix "B".

17. Brian Zebley was born with brain damage manifested by spastic right hemiparesis and mental retar-

dation. He suffers from developmental delay, eye problems and muscle skeletal impairments on the right side.

18. Brian Zebley walks with a limp, has trouble falling down and cannot go downstairs without help. He has problems with dexterity in his right arm. He slurs his words, has problems with drooling, and although four years old is not yet toilet trained.

19. On a mental development scale, Brian Zebley functions at less than two years of age.

20. It was nonetheless the decision of the Secretary that Brian Zebley was not disabled within the meaning of the Act since he did not meet or equal a listed impairment. No consideration was given to Brian's functioning, nor to any factor comparable to medical and vocational factors considered for adults.

VI. SUPPLEMENTAL SECURITY INCOME DISABILITY PROGRAM

21. In order to be eligible for Supplemental Security Income 42 U.S.C. § 1383, *et seq.* an individual must meet a test for disability, blindness or old age, and meet certain income and resource tests of need under 42 U.S.C. § 1382.

22. 42 U.S.C. § 1382(c)(a)(3)(A) provides that a child will be considered disabled "if he suffers from any medically determinable physical or mental impairment of comparable severity" to that which disables an adult under the program.

23. The Secretary has established three routes by which an adult may prove disability, known as (a) "listed impairments"; (b) "medical equivalence", (c) "medical and vocational factors" 20 C.F.R. § 416.901-920.

24. The Secretary has provided a child under age 18 will be considered disabled if he is "suffering from any medically determinable physical or mental impairment

which compares in severity to an impairment that would make an adult disabled "20 C.F.R. § 416.906, but provides that the determination of comparability is limited to an impairment which meets the duration requirement and (1) is listed in Appendix 1 of subpart P of part 404 of this chapter; or (2) is determined by us to be medically equal to an impairment listed in Appendix 1 of subpart B of part 404 of this chapter." 20 C.F.R. § 416.923.

25. Accordingly for children who claim disability no consideration is given to the functional equivalent or comparable factors available to an adult under 20 C.F.R. § 416.920(e), (f), 416.921, 416.922, 416.945, 416.971-975.

26. Thus a child receives no consideration for the age comparable individualized consideration of pertinent facts such as capacity to undertake basic activities, learning, growth, development, academic attainment, school performance and capacities and functional limitations imposed by physical or mental impairments.

27. Plaintiff has accordingly exhausted his administrative remedies within the meaning of the statute and decisions of this court.

28. Plaintiff and members of plaintiffs class have been terminated, or threatened with termination of benefits, or have been denied benefits without authority.

29. The above constitutes fixed and final policies and practices of the defendants affecting the plaintiffs class as a whole.

30. Federal defendants have acknowledged that most SSI beneficiaries rely upon their disability payments to provide the necessities of life.

31. Plaintiffs will suffer immediate and irreparable harm, including loss of these necessities of life, emotional language and distress, and loss of life if preliminary and permanent conjunctive relief is not granted.

VII. CLAIMS OF PLAINTIFFS CLASS AND NAMED PLAINTIFFS

FIRST CLAIM

32. Defendants as a matter of fixed policy and regulations refuse to consider "all pertinent facts" and medical and vocational factors in determination of disability for children in violation of a Social Security Act, 42 U.S.C. § 1382(a)(3)(A).

SECOND CLAIM

33. Defendants as a matter of fixed policy arbitrarily and capriciously and without authority violate due process and equal protection guarantees of fundamental fairness embodied in the 5th Amendment requiring child disability applicants and recipients to meet a more stringent standard than that applied to adults.

THIRD CLAIM (BRIAN ZEBLEY)

34. The final decision of the Secretary with regard to Brian Zebley should be reversed and/or remanded for reasons including but not limited to the following: (a) The decision is not supported by substantial evidence; (b) The decision fails to give appropriate weight to treating physicians' opinions and evidence; (c) The decision unlawfully relies on, in derogation of the substantial evidence in the file, the opinion of non-treating physicians who have not examined claimant.

(c) The position taken by the Secretary is otherwise not substantially justified, supported by substantial evidence or in conformity with the law.

WHEREFORE, Plaintiff prays this Honorable Court:

(1) That this Court take jurisdiction of the action and declare this a class action pursuant to 23(a), (b1) and (b2), Federal Rules of Civil Procedure;

(2) That this Court, pursuant to 28 U.S.C. § 2201 and 2202 and Rule 57, Federal Rules of Civil Procedure, declare that the defendants are erroneously and illegally threatening to terminate, terminating, or denying plaintiffs and their class members SSI benefits by requiring they meet a standard which is separate and more restrictive for child claimants than adults in violation of 42 U.S.C. § 1382(c)(3)(A).

(3) That this Court, pursuant to Rule 65, Federal Rules of Civil Procedures, grant preliminary and permanent injunctive relief, enjoining defendants from terminating or threatening to terminate, denying or threatening to deny SSI child claimants, named plaintiff, and their class members based on a requirement that children meet a separate and more restrictive standard for disability than that applicable to an adult;

(4) Enter judgment in favor of named plaintiff and against defendant reversing defendants decision that plaintiff is not disabled in that plaintiff does meet or equal even the restrictive standard unlawfully employed by defendants, and ordering defendant to pay benefits in accordance with title XVI of the Social Security Act, or in the alternative, vacate the administrative decision appealed from, remanding this matter to the Social Security Administration for further proceedings which will comport with the requirements of the act;

[sic] (4) That this court grant plaintiffs counsel fees and costs for pursuing this action under the Equal Access to Justice Act, 28 U.S.C. A. § 2412 (Supplement 1981), and the Civil Rights Attorneys fees awards act of 1976, 42 U.S.C. A. § 1988.

(5) That such other relief be granted as found just and proper.

/s/ M. Kaufman

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 83-3314

BRIAN ZEBLEY, ET AL.

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND
HUMAN SERVICES

[Filed Jan. 11, 1984]

ORDER

AND NOW, this 10th day of January, 1984, upon consideration of plaintiffs' motion for class certification and defendant's opposition thereto, it is ORDERED:

1. Plaintiff's motion is GRANTED, to the extent set forth below.¹

¹ Class-action treatment is appropriate to address the validity and interpretation of the regulations establishing the standards for determining child disability entitlements. To adopt the defendant's arguments would virtually repeal Federal Rule 23. On the other hand, I reject plaintiff's proposed class definition, since it presupposes the correctness of plaintiff's legal argument on the merits; to adopt plaintiffs' definition of the class would mean that, if plaintiffs lose, the class would have been decertified.

2. This action may be maintained as a class action pursuant to F.R.C.P. 23(b)(2), on behalf of a class defined as follows:

"All persons who are now, or who in the future will be, entitled to an administrative determination (whether initially, on reconsideration, or on reopening) as to whether supplemental security income benefits are payable on account of a child who is disabled, or as to whether such benefits have been improperly denied, or improperly terminated, or should be resumed."

/s/ John P. Fullam

J.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 83-3314

BRIAN ZEBLEY, 201-58-0223

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND
HUMAN SERVICES

[Filed Oct. 12, 1984]

MEMORANDUM AND ORDER

FULLAM, J.

Since his birth on July 13, 1978, Brian Zebley has been afflicted with spastic right hemiparesis¹ and mental retardation. He was granted supplemental security income benefits based on his application of September 12, 1980. Subsequently, however, the Social Security Administration determined that his disability ceased as of May 1982, and that his eligibility for benefits terminated on July 31, 1982. Plaintiff, through his father, requested a post-termination hearing before an Administrative Law Judge (ALJ) but waived his right to appear.

¹ Hemiparesis is a weakness affecting the muscles on one side of the body. Schmidt's Attorney's Dictionary of Medicine at H-36 (1981).

On January 15, 1983, the ALJ issued his decision, in which he concluded that plaintiff was no longer disabled. Because the Appeals Council denied review, the ALJ's report stands as the final decision of the Secretary. That decision, however, is not supported by substantial evidence. Accordingly, plaintiff's motion for partial summary judgment must be granted and the matter remanded to the Secretary for calculation and award of benefits.²

In a termination proceeding such as this, a claimant must first introduce evidence that the underlying condition persists. Thereafter, he or she is entitled to a presumption of continuing disability. The burden then shifts to the Secretary, who must demonstrate an improvement in the claimant's condition such that the claimant is no longer disabled. *Kuzmin v. Schweiker*, 714 F.2d 1233, 1237 (3d Cir. 1983). Ordinarily, determining whether such improvement has occurred is a relatively straightforward matter of comparing the claimant's former condition with his or her current condition and determining whether the claimant can now undertake gainful activity.

Here, however, the claimant is a child suffering from developmental impairments, but whose capabilities have admittedly increased as he has gotten older. Thus, in one limited sense of the word, his condition has improved. Nonetheless, the medical evidence demonstrates that, adjusting for age, Brian is no better off now than he was when benefits were initially awarded in 1980. Consequently, it cannot be said that there is substantial evidence of improvement.

² On January 11, 1984, this court granted plaintiff's motion for certification of a class action challenging the validity of the Secretary's regulations governing the award of disability benefits to minors. In this motion for partial summary judgment, plaintiff assumes *arguendo* that the existing regulations are valid but contends that his termination was not proper under those regulations.

Benefits were initially awarded on October 24, 1980. Although the record before this court does not explicitly state what information was before the original disability examiner in 1980, several of the reports in this record are addressed to her and presumably formed the basis for her decision. Chief among these is a report dated October 22, 1980, from Dr. Mark Cohen, Brian's treating neurologist. Dr. Cohen concluded that Brian's "personal social and fine motor-adaptive skills are at approximately the 15 month level and his gross motor and language skills are at approximately the 12 month level." R.61. Thus, Brian's skills were at approximately 55% and 45% of the norm for his age of 27 months.

In determining that Brian was no longer disabled as of May 1982, the second disability examiner (and later the ALJ) relied upon reports by several treating physician and psychologists. One group of reports concerned surgery that Brian underwent to his right leg on February 24, 1982, namely, when his right Achilles tendon was lengthened. Thereafter, the supervising orthopedic surgeon noted that the operation was very successful in correcting Brian's gait. R.84.

Also considered by the second disability examiner was a report by Erika Surkin, M.Ed., a certified school psychologist, and Sharon Elvey, a resident in pediatrics. Ms. Surkin is a staff member at the Delco Elwyn Institute Development Center, where Brian has participated in various developmental therapy programs. She performed a psychological evaluation of Brian on July 2, 1981, when he was 11 days shy of his third birthday. She administered the Griffiths Mental Development Scales test, on which Brian achieved an overall mental age of 24.4 months, and a general intelligence quotient of 68. R.64-68. The report of Dr. Elvey is much less specific, but states that Brian is significantly delayed in his development. R. 76, R.86.

On September 20, 1982, the ALJ who was reviewing Brian's termination submitted the record to Dr. Gunter Haase, a board-certified neurologist and psychiatrist and professor of neurology at Pennsylvania Hospital. The ALJ requested that Dr. Haase review the record and respond to interrogatories. Dr. Haase replied on October 14, 1982, agreeing with the diagnosis of mental retardation and right hemiparesis. He concluded, however, that "The level of severity of these impairments is relatively mild," and that they did not rise to the level of a disability.

Of particular significance to this court's review of the ALJ's decision is a second report from Ms. Surkin, dated July 21, 1982. On that occasion, when Brian was just over 48 months old, he achieved the following scores on the Development Programming Test:

Perceptual/fine motor:	24 to 27 months
Cognition:	36 to 42 months
Language:	36 to 42 months
Social/emotional:	36 to 42 months
Self help:	20 to 23 months
Gross motor:	16 to 19 months

Ms. Surkin further commented that Brian had difficulty with motor coordination. His gross motor skills were limited by spasticity and incoordination. His balance was often poor when walking and climbing. One side was significantly weaker than the other. His motor problems are apparent with fine motor tasks. He had difficulty with items requiring fine coordination and depth perception. Brian held his head to the right and appeared to be using his right eye predominantly. He often misjudged distances.

R.103. A physical therapist at the Delco Center reported on July 15, 1982 that Brian's balance was poor and that he

fell frequently, though the operation on his heel had improved his foot and knee alignment. R.104. The ALJ submitted those additional reports to Dr. Haase and asked whether they warranted a change in Dr. Haase's evaluation. Dr. Haase responded as follows:

The additional material submitted includes a report, dated July 2, 1981, according to which Brian Zebly's intelligence quotient is 68. In another report dated July 21, 1982, I do not see a specific reference to the intelligence quotient but it would appear that the results at this time are consistent with those obtained one year previously.

In those sections of the Social Security Regulations specifically pertaining to children, under paragraph 112.05, the description reads "I.Q. of 60 - to 69, inclusive and the physical or other mental-impairment imposing additional and significant restriction of function or developmental progression.["] In this particular case, the accent would have to rest on the statement 'a physical or other mental impairment. . .'. There is evidence in the records that in Brian Zebly there is existing such a physical impairment because of spasticity which also has produced 'trouble walking' because of his poor balance. Nevertheless, he is described as riding his tricycle, playing ball, being able to walk upstairs, but requiring help walking down. It is also said, 'Brian enjoys fine motor activities. He is able to place shapes in a shape sorter and complete simple form boards and puzzles.'

It further is said that he 'feeds himself finger foods and uses a spoon, a fork with some help, and a cup. He is able to remove his coat and shirt independently.'

In my view, this would indicate that he has impairments in fine motor functions but the records would indicate that this does not represent a "additional and significant restriction of function or developmental progression."

As I understand the Social Security Regulations, the impairments of Brian Zebly would not meet these specific requirements.

R.106-07.

In reaching his decision, the ALJ relied heavily upon Dr. Haase's assessment. That reliance presents problems for two reasons. First, the Third Circuit has recently cautioned that expert medical opinions based on a paper record have "less probative force" than those based on a direct examination of a claimant. *Wier v. Heckler*, 734 F.2d 955, 963 (3d Cir. 1984). Second, and more seriously, Dr. Haase does not appear to have taken into account results of the gross motor and self-help skills tests. As noted above, Brian's skills in these areas were found to be at the 16-19 months, and 20-23 months, respectively. Given that Brian was 48 months old at the time those tests were administered, a conclusion that his development progression was not significantly restricted seems hardly supportable. Yet Dr. Haase drew that conclusion and the ALJ accepted it.

In addition, the ALJ mischaracterized the July 5, 1982 report of Brian's physical therapist. The ALJ stated that that report "implies that Brian's past problems with poor balance and frequent falling might be substantially eliminated by a properly fitted brace and the heel surgery." R.13. Although the therapist did state that Brian had outgrown his short leg brace and recommended that he get a new one, the heel surgery had been performed five months before the therapist's evaluation. Nonetheless, the

therapist noted that Brian's balance was still poor and he still fell frequently. Nowhere does the therapist's report imply that a new brace would correct the remaining problems. R.104.

In sum, there is no substantial evidence supporting the ALJ's conclusion that Brian's disability had ceased because he no longer suffered from a "significant restriction of . . . developmental progression." Instead, all of the first-hand recent medical evidence is to the contrary. Given that Brian has an I.Q. of 68, he therefore continues to meet the criteria of 112.05C, and should not have had his benefits terminated. This matter will accordingly be remanded to the Secretary for calculation and award of benefits.

This ruling does not, of course, preclude the Secretary from subsequently determining that Brian's condition has improved to such a degree that his benefits should be terminated, if there is evidentiary support for that conclusion.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 83-3314

BRIAN ZEBLY

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND
HUMAN SERVICES

ORDER

AND NOW, this 9th day of October, 1984, it is ORDERED that:

1. Defendant's Motion for Partial Summary Judgment is DENIED.
2. Plaintiff's Motion for Partial Summary Judgment is GRANTED. The case is remanded to the Secretary for calculation and award of benefits.

/s/ John P. Fuilam

J.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 83-3314

IN THE MATTER OF EVELYN RAUSHI,
POTENTIAL INTERVENOR,

BRIAN ZEBLEY, BY HIS PARENT AND NATURAL GUARDIAN,
JOHN ZEBLEY, PLAINTIFF

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND
HUMAN SERVICES, DEFENDANT

[Filed Mar. 13, 1985]

ORDER

AND NOW, this 13th day of March, 1985, upon consideration of the Secretary's uncontested motion, it is hereby

ORDERED

that the claim of intervenor Evelyn Raushi *only* is remanded to the Secretary of Health and Human Services pursuant to section 2 of the Social Security Disability Benefits Reform Act of 1984 for review in accordance with the provisions of the Social Security Disability Act as amended by section 2 of Pub. L. 98-460.

Evelyn Raushi's Social Security Number is 171-60-9163.

BY THE COURT:
/s/ John P. Fullam

J.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 83-3314

IN THE MATTER OF JOSEPH LOVE JR., PLAINTIFF

BRIAN ZEBLEY, PLAINTIFF

v.

MARGARET HECKLER, SECRETARY OF HEALTH AND
HUMAN SERVICES, DEFENDANT

[Filed Apr. 23, 1987]

ORDER

It is hereby ORDERED and DECREED, that the claim of Joseph Love Jr., by his mother Marguerite Love, for Supplemental Security Income benefits be REMANDED to the Secretary of Health and Human Services for a determination of eligibility for benefits in accordance with the Social Security Disability Benefits Reform Act of 1984.

BY THE COURT:
/s/ John P. Fullam

J.

**DEPARTMENT OF HEALTH &
HUMAN SERVICES**

Social Security Administration

Refer to:
SGC
201-58-0223

May 20, 1983

Office of Hearings and Appeals
PO Box 2518
Washington DC 20013

ACTION OF APPEALS COUNCIL ON REQUEST FOR REVIEW

Mr. John Zebley
for Brian Zebley
106 Washburn Street
Upland, PA 19015

Dear Mr. Zebley:

The request for review of the hearing decision in your case has been considered.

Section 416.1470 of Social Security Administration Regulations No. 16 (20 CFR 416.1470) provides that the Appeals Council will grant a request for review of a hearing decision where: (1) there appears to be an abuse of discretion by the administrative law judge; (2) there is an error of law; (3) the administrative law judge's action, findings, or conclusions are not supported by substantial evidence, or (4) there is a broad policy or procedural issue which may affect the general public interest. This section also provides that where new and material evidence is submitted with the request for review, the entire record will be evaluated and review will be granted where the Appeals Council finds that the administrative law judge's action, findings, or conclusion is contrary to the weight of the evidence currently of record.

The Appeals Council has concluded that there is no basis under the above regulations for granting the request for review. Accordingly, your request is denied and the hearing decision stands as the final decision of the Secretary in your case.

If you desire a court review of the hearing decision, you may commence a civil action in the district court of the United States in the judicial district in which you reside within sixty (60) days from the date of receipt of this letter. It will be presumed that this letter is received within five (5) days after the date shown above unless a reasonable showing is otherwise made. See section 1631(c)(3) of the Social Security Act, as amended (42 U.S.C. 1383(c)(3)) and section 422.210 of Social Security Administration Regulations No. 22 (20 CFR 422.210).

If a civil action is commenced, your complaint should name the Secretary of Health and Human Services as the defendant and should include the Social Security number(s) shown at top of this notice.

Sincerely yours,

/s/ VERRELL L. DETHLOFF, JR.
Verrell L. Dethloff, Jr.
Member, Appeals Council

cc:

Mr. Timothy W. Hunter
Chester, PA 19013

HO, Philadelphia, PA (ALJ Ennis, Jr.)

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BUREAU OF HEARINGS AND APPEALS

DECISION

IN THE CASE OF

JOHN ZEBLEY FOR BRIAN
(Claimant)

Claim for
Continuance of Disabled Child's
Supplemental Security Income

201-58-0223

(Wage Earner) (Leave Blank if same as above)

(Social Security Number)

This case is before the Administrative Law Judge on a request for hearing. A hearing was scheduled but not held, and the child's father waived his right to appear and testify, although fully informed of his right to do so, requesting instead that the decision be based on the written record alone. Claimant is represented by Timothy Hunter, a legal intern.

ISSUES

The general issue before the Administrative Law Judge is whether the claimant continues to be eligible for supplemental security income under Section 1614 of the Social Security Act. The specific issues are whether the claimant continues to be under a "disability" as defined in the Act and, if not, when such "disability" ceased.

LAW AND REGULATIONS

Section 1614(a)(3)(A) of the Social Security Act provides that a child under the age of 18 shall be considered to be disabled if he has any medically determinable physical or mental impairment which can be expected to result in

death or which has lasted or can be expected to last for a continuous period of not less than twelve months of comparable severity to that which would render an individual unable to engage in substantial gainful activity.

EVALUATION OF THE EVIDENCE

Based on an application filed September 12, 1980, Brian M. Zebley was granted Supplemental Security Income Benefits, payable to his natural father, John H. Zebley, pursuant to a finding that he was under a disability as defined in the Social Security Act. Subsequently, the Administration determined that the child's disability ceased in May, 1982 and that his eligibility for supplemental security income terminated July 31, 1982. Although development which ultimately led to that determination was begun as early as March, 1982 (see Exhibit 7), the parties were first informed of the determination by letter dated June 2, 1982 (Exhibit 4), the earliest communication which comports with the Secretary's program regarding due process notice in disability cessation cases. A timely request for hearing then was filed June 15, 1982.

The record indicates that claimant was born July 13, 1978 and presently is 4 years, 6 months old. Since about age one, the child has been attending stimulation and enrichment schooling in conjunction with the Delco Elwyn Institute.

Brian was born with brain damage manifested by spastic right hemiparesis and mental retardation (Exhibit 10). When evaluated in June, 1979 in connection with the Delco Elwyn Institute Infant Stimulation Program, the child had significant limitations in gross motor, strength, and language areas, although vision and fine motor control appeared to be satisfactory (Exhibit 8); overall, his

evaluators felt him to be functioning at about one-half of his chronological age (Exhibit 12).

Dr. Baker, one of the child's treating physicians, reported that he sat at 12 months, crawled at 15 months, and was speaking two-word [sic] combinations at 21 months, and overall appeared to be developing better than was expected considering the limitations apparent at birth (Exhibit 9). Similarly, when Dr. Cohen evaluated the child in October, 1980 for the Administration, he measured height, weight, and head circumference to be in the 25th to 50th percentile, and noted that his personal, social, and fine motor adaptive skills appeared commensurate with his chronological age; gross motor and language skills continued to lag, however (Exhibit 13).

Brian was re-evaluated July 2, 1981 by Erika Surkin, a Certified School Psychologist for the Delco Elwyn Institute (Exhibit 15). At the time, the child was 35 months old. His mental age was tested at 24 months, and subtests concerning social skills, eye-hand coordination, and performance ranged from 21 to 26 months. A companion Preschool Attainment Record test, based on assessments by his parents and on observations of the child was scored at 26 months. Qualitatively, Brian had good fine motor control; was friendly, sociable, and cooperative; was "quite verbal;" and was able to walk and climb stairs but, due to problems with his right leg and foot, often bumped into obstacles and had difficulty descending stairs.

Dr. Vanace, claimant's treating neurologist, found that his right leg and right arm both were about one-quarter short compared with their opposite members on the left, and that the child had some right hip subluxation. He prescribed the fitting of a right leg brace and an orthosis in the right shoe (Exhibit 16). On February 24, 1982 Brian's

right Achilles tendon was lengthened in a procedure at Einstein Medical Center by Dr. Guttman (Exhibit 17). As of May, 1982, Dr. Guttman assessed the procedure as having been successful; both the child and his parents were pleased with the results, he was normal weight-bearing, abnormalities of gait were substantially resolved, and the child had more endurance for walking. Dr. Guttman felt that no further surgery was required (Exhibit 21).

A full re-evaluation of the child was completed in July, 1982 by Ms. Surkin; Brian's teacher, Eileen Flynn joined in the psychological evaluation, and Peggy Daniel, a physical therapist, evaluated his physical capabilities (Exhibit 28). Brian was 48 months old in July, 1982. Psychologically, the following findings as to the child's skills were made: perceptual/fine motor, 24 to 27 months; cognition, 36 to 42 months; language, 36 to 42 months; social/emotional, 36 to 42 months; self/help, 20 to 23 months; gross motor, 16 to 19 months. Specifically, Brian was able to scribble, align toys, and unscrew a jar lid; group pictures and identify shapes and objects; follow simple commands and use simple sentences spontaneously; play simple games with other children and help with household tasks; wash and dry hands independently, and operate a large zipper; and ascend and descend stairs, sit himself, and run. Moreover, he was beginning to be able to stack eight cubes, identify dissimilar items, use a variety of words, verbally describe his activities, use buttons and shoe laces, and ride a tricycle and kick and throw balls. Qualitatively, Brian continued to display some difficulties with verbalization and motor coordination, but he was friendly, cooperative, and was able to engage in a wide variety of activities despite his physical impairments. Ms. Daniel indicated that Brian's right heel surgery provided better foot placement and knee alignment, and that the

child had outgrown his short leg brace; her report implies that Brian's past problems with poor balance and frequent falling might be substantially eliminated by a properly fitted brace and the heel surgery.

This record was submitted to Dr. Gunter Haase, a board-certified neurologist and psychiatrist, and Professor of Neurology and Director of the Department of Neurology of the Pennsylvania Hospital. Dr. Haase stated that the medical findings support the diagnoses of mental retardation, right hemiparesis, spastic weakness of the right side, and developmental delay. All impairments are, however, relatively mild. Specifically, it was his medical judgment that the child had no impairment which satisfied the requirements of the sections of the Listing of Impairments with respect to neurological, or mental and emotional disorders. He also indicated that the child has no impairment or combination of impairments which equals the requirements of any section. (Exhibits 26, 30)

Mr. Zebley certified that Brian "has easily observed disabilities in his coordination, comprehension, speech, learning ability, and physical abilities." Compared with his other children, Brian is "noticeably slower" in all such areas. On the other hand, his affidavit indicates that the child can walk without assistance, use stairs, speak and communicate understandably, and is able to learn (Exhibit 31). An earlier document (Exhibit 6) states that Brian attends school daily from eight in the morning and til 3:30 in the afternoon, then spends the balance of the day playing with toys and other family members, and watching television.

This record shows that Brian Zebley has significant limitations compared with other children of his age. However, physically he is able to walk, use stairs, and even run;

while he cannot engage in these activities to the extent and for the time expected of an unimpaired child, he can do them to a substantial degree. Similarly, the record establishes that Brian is somewhat slow to learn, has speech impairments, and lags behind his peers in attaining developmental milestones. But the July, 1982 psychological evaluation establishes that developmental delay is not as great as one-half his chronological age except as to self/help and gross motor skills, and even as to them, development is continuing apace.

Considering the activities Brian is able to engage in, and comparing the July, 1982 Elwyn Institute evaluation with that administered in July, 1981, the undersigned concludes that Dr. Haase's assessment is correct, substantiated by the preponderance of the record. Accordingly, the Administrative Law Judge concludes, that the record does not establish the existence of any impairment or combination of impairments which meets or equals the requirements of any section of Listing of Impairments at Appendix 1. In reaching this conclusion, the undersigned particularly considered Sections 100.00 (growth impairment), 102.00 (special senses and speech), 111.00 (neurological), and 112.00 (mental and emotional disorders). Although Mr. Hunter skillfully and forcefully argues that Section 112.05 applies in this case, the undersigned is persuaded that the child's physical impairments do no impose a significant restriction of function or developmental progression as required by that section.

Accordingly, the undersigned concludes that claimant's disability, as defined by the Social Security Act, ceased. In accord with due process requirements, however, the effective date of cessation is June, 1982, rather than April, 1982 as originally determined, and the child's eligibility for supplemental security income thus terminates on August 31, 1982.

FINDINGS

After careful consideration of the entire record, the Administrative Law Judge makes the following findings:

1. Brian Zebley was born July 13, 1978, the natural child of John Zebley.
2. Based on an application filed September 12, 1980, the child was granted Supplemental Security Income benefits.
3. The record reflects complaints and treatment of exertional and non-exertional impairments, chiefly congenital brain damage with spastic right hemiparesis, mental retardation, developmental delay, eye problems and musculoskeletal impairments on the right.
4. The record does not establish the existence of any impairment or combination of impairments of a level of severity which, as of June, 1982, meets or equals the requirements of any section of the Listing of Impairments at Appendix 1.
5. The claimant was not under a disability as defined by the Social Security Act from June, 1982 onward, through the date hereof.
6. The claimant was first informed by the Administration that disability ceased in June, 1982.

DECISION

It is the decision of the Administrative Law Judge that, based on the application filed September 12, 1980, claimant's disability ceased as of June, 1982, and his eligibility for supplemental security income terminated August 31,

1982, pursuant to Sections 1614 and 1631 of the Social Security Act.

January 26, 1983

Date

JOHN W. ENNIS, JR.

John W. Ennis, Jr.
Administrative Law Judge

**DEPARTMENT OF
HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS**

DECISION

**IN THE CASE OF
MARGUERITE LOVE FOR
JOSEPH LOVE JR.**

(Claimant)

Claim for
**Supplemental Security
Income (Child)**

199-52-7659

(Wage Earner) (Leave Blank if same as above) (Social Security Number)

This case is before the Administrative Law Judge on a request for hearing. The Administrative Law Judge has carefully considered all the documents identified in the record as exhibits, the testimony at the hearing and arguments presented.

ISSUES

The issue before the Administrative Law Judge is whether the claimant is disabled under section 1614(a)(3)(A) of the Social Security Act. The Act defines "disability" as the inability to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment(s) which can be expected to either result in death or last for a continuous period of not less than 12 months or, in the case of a child under the age of 18, if he or she suffers an impairment of comparable severity.

The specific issues are whether the claimant, a child under the age of 18, is under a "disability" and, if so, when such disability commenced and the duration thereof.

**APPLICABLE REGULATIONS AND EVALUATION
OF THE EVIDENCE**

Pursuant to the Act, the Secretary has established Social Security Administration Regulations No. 16. Section 416.923 of the Regulations provides that a child under age 18 is disabled if he or she (a) Is not doing any substantial gainful activity; and (b) Has a medically determinable physical or mental impairment(s) which compares in severity to any impairment(s) which would make an adult (a person age 18 or over) disabled. This requirement will be met when the impairment(s) —

- (1) Meets the duration requirement; and
- (2) Is listed in Appendix 1 of Subpart P of Regulations No. 4; or
- (3) Is determined to be medically equal to an impairment listed in Appendix 1 of Subpart P of Regulations No. 4.

The Listing of Impairments describes, for each of the major body systems, impairments which are considered severe enough to prevent a person from doing any gainful activity. The Listing of Impairments consists of Parts A and B. In evaluating disability for a person under age 18, Part B will be used first. If the medical criteria in Part B do not apply, then the medical criteria in Part A will be used.

In applying the criteria outlined above, the Administrative Law Judge concludes that the claimant does not have any impairment which is listed in Appendix 1, Subpart P, Regulations No. 4. Furthermore, he does not have an impairment or combination of impairments which is medically equal to an impairment listed in Appendix 1. Accordingly, it must be found that the claimant, who has not attained age 18, is not disabled within the meaning of the Social Security Act.

The claimant was born on February 26, 1973. The reports from the claimant's school district showed that he was originally begun in regular class work although it was recommended in 1979 that he be placed in a learning disabled classroom. In the regular classroom situation he failed first grade three times and was begun in a special learning class in 1981 but was unable to adapt to the program. With efforts to have him entered into alternate special education classes failed in early 1983 he was begun in the homebound instructional program. As of April 1983 Mr. Patrick Ahern, the director of special education, stated that he continued to receive instructions at home since no placement had been worked out, (Exhibits 26, 27).

At the hearing the claimant testified that he used to go to Columbus school but now has a tutor who comes to his house. As part of his school work he reads the Dinosaurs reading book and was able to identify the characters in the book and spell short words. He was able to perform minor addition and subtraction but could not do any problems where a digit or total was over 10. He could print and write a little in cursive. When asked to why he was no longer attending the Columbus school he stated that he was too smart for the teachers and they unable to handle him. He stated that he was hated by the other children in the school and they physically abused him. He is able to ride a two wheel bike, likes to color and sometimes gets in fights with children on his street.

The claimant's mother testified that the Columbus school was a special education class but they could not cope with the claimant because they could not give him enough of their time and he was constantly running about. He spent one year in kindergarten and three years in first grade. He usually goes to sleep at two [sic] a.m. and wakes

at 6 a.m. He has been unable to sit still and climbs on top of things constantly. He constantly slides across the floor and runs up and down steps. He fights with his six year old brother. He has a short attention span and does not always finish watching a whole television program. He is very good at drawing but only does it for about five minutes. He can work puzzles containing thirty to sixty pieces. He gets upset easily and when left with a sitter will cry. He will argue with her and is too fearful to leave the bathroom door closed because he does not like to be left alone. He becomes depressed and moody. He cannot write a sentence on his own but can copy it. He must sleep on a mattress on the floor because he is active while he sleeps. He is not allowed to play outside because he is always getting into fights with others. His tutor has difficulty getting his attention, they argue and his mind wanders. He will not stay seated during the tutoring, constantly jumping up, grabbing at papers and frustrating his tutor. The claimant had been on medication for hyperactivity but she discontinued giving it to him because it was not doing him any good. He has been treated by Dr. Ivans on and off over the last four years. He helps with the dishes occasionally and takes of his personal needs normally.

The medical evidence shows that the claimant had received outpatient treatment at the Crozier-Chester Hospital as early as November 1976 for a moderate bilateral conductive hearing loss but he had excellent speech discrimination. It was felt that he had middle ear pathology possibly secondary to a fluid build up. He was also seen for vague abdominal pains, complaints of joint pain, shaking and bronchitis, (Exhibit 5). Dr. Steven Fischer reported in August 1981 that the claimant had bilateral serous otitis and underwent surgery in April 1980 for the implantation of tympanic ventilation tubes. By July 1981 the tubes were

extruded and the ears appeared to look well. Testing showed his hearing to be normal with only a mild conduction deficit and again he had excellent speech discrimination, (Exhibit 10).

The claimant was examined by Dr. Frank Rosenberg on September 1, 1981 and appeared thin but well developed. It was stated that he had some asthma but hyperactivity was his main problem. He was receiving no medication for the asthma problem. A chest x-ray was normal as were pulmonary function studies. An electrocardiogram showed signs of arrhythmia. He was felt to have no chronic lung dysfunction or any current symptomatology, (Exhibit 11).

Dr. Samuel Ivens reported that he had treated the claimant between March 1979 and May 1981. He described the claimant as a hyperkinetic child who performed satisfactorily in a learning disabled classroom. Weschler IQ testing showed him to range between 93 and 97. Motor-visual perception age was greater than his chronological age. Physical examination was normal. He had no limitation on his ability to care for himself, understand and follow directions or perform simple calculations. He was able to read and write appropriately with his age and grade level and could use public transportation, (Exhibit 9).

However, in August 1982 Dr. Ivens reported that the claimant had a normal IQ but was nine and one half years old with unusual behavior and still in kindergarten after four years. He was able to care for his needs at an age appropriate level and engaged in normal activity for a nine and one half year old. He appeared bright but loquacious. He diagnosed the claimant as suffering organic brain syndrome with a psychiatric and neurological impairment. The psychiatric impairment was described as adjustment

disorder with mixed disturbance of emotion and conduct. The neurological impairment was severe hyperkinesia and involuntary movements with visual/motor misperception, (Exhibit 18). On examination the claimant was described as being thin and pale. There were occasions of uncontrolled athetoid movements. There were no sensory abnormalities but he had difficulty with bilateral hand stereognosis, difficulty with visual/motor perception and hyperreflexivity, (Exhibit 26).

The claimant was examined by Dr. John Liebert, a psychologist in September 1981. The claimant was described as being very distracted during the testing, moving about and humming. His IQ was tested as 99 in the average range. Subtesting showed possible learning disorder but he had above average recall of information, attendance and concentration. He had a low symbol matching accuracy which was indicative of a visual motor perceptual problem which was also suggested by the Bender-Gestalt testing, (Exhibit 13, 24).

The claimant had been referred to Dr. Elinor Weeks, a child psychologist, who reported in February 1982 that he suffered from adjustment disorder with mixed disturbance of emotion and conduct. He was described as being very impulsive, apprehensive and a poor learner. He was unable to relate with his peers, control his aggressions easily or learn. He was appropriate in his ability to care for himself, understand the spoken work, follow instructions and do simple calculations. He had a poor ability to read but could write. He was being treated with Cylert, (Exhibits 16, 17).

The claimant also underwent psychological evaluation under Jolene Sims in June 1982. He stated that in a school classroom the claimant was aggressive both verbally and

physically, disruptive and uncooperative in his behavior. During the testing he chatted excessively. On the non-academic testing he was alert, interested and motivated, but on the academic testing he was lethargic, apathetic and evasive because he felt threatened and inadequate. Weschler Child IQ testing showed him to be in the 98-120 range, the average-high average range. There were no signs of any perceptual impairment. He had strengths in using words and abstract associative reasoning. He had reduced practical knowledge and common sense. He scored high average to superior on performance tests using visual comprehension and discrimination and spatial perception. There were some remnants of a visual/perception deficit which had been present in the past. It was felt that his perceptual problems had diminished considerably. He exhibited severe emotional stress secondary to his academic failures which were felt to be the cause of his poor adjustment in the learning disabled program, (Exhibit 26).

The medical evidence does not establish that the claimant has any severe physical impairment. The physical testing has been essentially negative with no indication of any significant neurological or pulmonary impairment, (Exhibit 5, 11). The evidence establishes that the claimant has no significant residual hearing problem, (Exhibit 10). Dr. Ivens does state he has neurological impairment due to severe hyperkinesia and involuntary movements but there were no clinical findings by either Dr. Ivens or a neurologist to support the existence of any significant neurological impairment. No such neurological involvement was mentioned in any of the other examinations, it was commented upon during any of the psychological testing. The most recent psychological testing of June 1982 did not show any significant continuing performance difficulty because of a

neurological problem, (Exhibit 26). Additional time was given for submission of a report of a neurological examination the claimant was stated as having undergone but no such report was received. The statements in the record and the testimony of the claimant and his mother as to his ability to perform normal activities around the house and take care of his personal needs did not reflect any significant neurological problems.

The evidence establishes that the claimant has a normal to high average intelligence. The evidence does show that he suffers from hyperactivity with an adjustment disorder with a mixed disturbance of emotion and conduct. However, the evidence does not show that this is severe enough to meet or equal any of the Listings of Impairments contained in Appendix I of Subpart P of Regulation No. 4. The severity of the impairment, which is indicated by Dr. Ivens in Exhibit 18, is not consistent with his earlier statements in Exhibit 9 that the claimant was able to perform satisfactorily in class, (Exhibit 9). A great deal of effort has been made to fully develop the record but the evidence which has been obtained does not establish the condition is severe enough to meet or equal any of the Listed Impairments. The claimant's actions and demeanor at the hearing were not consistent with the severity of his emotional and behavioral problems as testified to in the record. He was able to sit tolerably still during the hearing however he fidgeted somewhat in his seat. He was able to understand all the questions posed to him and responded appropriately.

The medical evidence of record was submitted to Dr. Margaret A. Friel, a board-certified pediatrician and child psychiatrist, who is a medical advisor to the Secretary. It was Dr. Friel's opinion that based upon the evidence of record, no significant neurological impairment had been unequivocally established. She noted that while Dr. Ivens

had described a slight or minimal sensory change, in the same report he stated that the claimant had hyperreflexia with ewthetoid movements. This she felt was conclusionary and difficult to evaluate in the absence of other findings. The more recent neurological examinations made no mentions or abnormal findings in these areas. It was her opinion that the claimant did not have any neurological or physical impairment which would be of sufficient severity to meet or equal any of the impairments listed in Appendix 1 of Subpart P of Regulation No. 4.

Dr. Friel did believe that the diagnoses of adjustment disorder with mixed disturbance of emotion and conduct (DSN 309.40) and the diagnosis of attention defect disorder secondary to family stress were established by the evidence of record, especially the reports from Dr. Weeks in Exhibits 16 and 17. She described the claimant has having average intelligence with an academic handicap of a learning disability and the emotional handicaps associated with the psychiatric diagnosis. It was her opinion that on the basis of the evidence presented in the file the overall severity of the total situation was moderate, that is a rating of 3 on a scale of 1-5. She noted that he was able to function in a class for the learning disabled, such that it had not been necessary to confine him to a more restrictive environment, such as the Eastern State school or Hospital. He was described in the record as a bright child who was able to learn and would be able to pick up quickly when taught on the right level given adequate opportunity. She noted that in the testing he related comfortably to the various examiners and while he functioned emotionally at home and at school with problems of adjustment these were not shown to be of a magnitude which would meet or equal any childhood listing in Appendix 1. While there was no doubt that he was compromised academically and

socially in her opinion the compromise did not meet or equal the severity required under the Listings for any impairment, (Exhibit 30).

The Administrative Law Judge finds that, for the reasons discussed herein, and the opinion of Dr. Friel the claimant has not had a physical, mental or emotional impairment of sufficient severity to meet or equal any of the Listed Impairments in Appendix 1, Part B, Subpart P of Regulation No. 4 and thus cannot be found disabled, as such is defined for a child under age 18.

FINDINGS

After careful consideration of the entire record, the Administrative Law Judge makes the following findings:

1. The claimant was born on February 26, 1973 and is a child under age 18.
2. The medical evidence establishes that the claimant has adjustment disorder with mixed disturbance of emotion and conduct and attention defect disorder secondary to family stress.
3. The medical evidence further establishes that the claimant does not have an impairment or combination of impairments either listed in or medically equal to one listed in Appendix 1, Subpart P, Regulations No. 4 (20 CFR 416.925 and 416.926).
4. The claimant was not under a "disability" as defined in the Social Security Act, at any time through the date of this decision (20 CFR 416.923).

DECISION

It is the decision of the Administrative Law Judge that, based on the application filed on June 5, 1981, the claimant is not eligible for supplemental security income under sections 1602 and 1614(a)(3)(A) of the Social Security Act.

/s/ Linda M. Bernstein
LINDA M. BERNSTEIN
Administrative Law Judge

June 10, 1983
Date

**DEPARTMENT OF
HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS**

DECISION

In the case of	Claim for
MARY RAUSHI FOR	Continuance of Supple-
<u>EVELYN RAUSHI</u>	mental Security Income
(Claimant)	<u>(Child)</u>
<u>(Wage Earner) (Leave</u>	<u>171-60-9163</u>
blank is same as above)	(Social Security Number)

This case is before the Administrative Law Judge on a request for hearing. The Administrative Law Judge has carefully considered all the documents identified in the record as exhibits, the testimony at the hearing and arguments presented.

ISSUES

The issue to be determined is whether the claimant continues to be disabled under section 1614(a)(3)(A) of the Social Security Act. The specific issues are whether the claimant's disability has ceased, and if so, when.

**APPLICABLE REGULATIONS AND EVALUATION
OF THE EVIDENCE**

Pursuant to the Act, the Secretary has established Social Security Administration Regulations No. 16. Section 416.994(c) of Regulations No. 16 provides that if an individual is under age 18, a finding that his or her disability ended will be in the earliest of the following months —

- (1) The month the impairment, as established by current medical evidence is not an impairment listed in Appendix 1 of Subpart P of Regulations No. 4 or is not equal to a listed impairment;
- (2) The month in which the individual demonstrated the ability to engage in substantial gainful activity (following completion of a trial work period).

The Listing of Impairments describes, for each of the major body systems, impairments which are considered severe enough to prevent a person from doing any gainful activity. The Listing of Impairments consists of Parts A and B. In evaluating disability for a person under age 18, Part B will be used first. If the medical criteria in Part B do not apply, then the medical criteria in Part A will be used.

The evidence of record shows that the claimant was found to be eligible for supplemental security income as a "disabled child" beginning August 13, 1979. However, it was determined that disability ceased as of October 1981. (It is the policy of the Social Security Administration that the month of cessation will ordinarily be the month that the claimant is informed that the Social Security Administration plans to find that disability has ceased. The question to be resolved is whether the claimant's impairment(s) singly or in combination continue to meet or equal those impairments listed in Part B of the Listing of Impairments at the time disability was found to have ceased.

In applying the criteria outlined above, the Administrative Law Judge concludes that since November 1981, the claimant has not had an impairment which is listed in Appendix 1, Subpart P, Regulations No. 4. Furthermore, since that date, she has not had an impairment or combination of impairments which is medically equal to an

impairment listed in Appendix 1. Accordingly, it must be found that the claimant, who has not attained age 18, is no longer disabled within the meaning of the Social Security Act.

Mary Raushi, the applicant, filed an application for supplemental security income on behalf of Evelyn Raushi, the claimant, on August 13, 1979. The claimant was born on December 30, 1974. The applicant is the claimant's mother. The claimant was found to be disabled due to mental deficiency. It was subsequently determined that her disability ceased in October 1981. The applicant disagrees with this determination, alleging that her daughter's disability continues. Her representative is Mark Kaufman, Esquire, of Delaware County Legal Assistance.

Mary Carol Hornyak, a school psychologist, evaluated the claimant on May 21 and 22, 1981. The claimant was noted to have a history of premature birth followed by jaundice and rubella. Another early problem noted was strabismus. A Stanford-Binet test was administered in October 1978 and the claimant's IQ score was 62. A new Stanford-Binet was administered at the May 1981 evaluation and the claimant's score was 82. WEAT scores were at the kindergarten level. Difficulties were noted in motor areas, such as spatial relationship problems, and in visual perceptual areas (Exhibit 32).

Dr. C. McCormick, a pediatric neurologist, examined the claimant on July 8, 1981. The claimant had a grand mal seizure in February 1981 but her seizure disorder was now described as controlled by medication. The examination was consistent with mild mental retardation but was otherwise unremarkable (Exhibit 49).

Dr. William Frayer, an ophthalmologist, submitted a letter dated August 26, 1981. The claimant had undergone

surgery for correction of esotropia in June. When last seen on July 29 she was described as doing well and her visual acuity was good (Exhibit 51).

Dr. Steven Barrer, a neurologist, examined the claimant on October 5, 1981. The claimant was reported to be alert and oriented. She was described as friendly and cooperative. She had no difficulty expressing herself or understanding commands. Neurologic examination was entirely normal (Exhibit 33).

Dr. Lawrence Gordon, an otorhinolaryngologist, examined the claimant on September 29, 1982. The ears were normal. Voice and speech were intelligible. Hearing was normal. There were no evident functional limitations based on ear, nose, and throat examination (Exhibit 55).

Dr. William Frayer, an ophthalmologist, submitted a letter dated January 7, 1983. He noted that the claimant had received surgery for congenital convergent strabismus. She has done well postoperatively and had visual acuity of 20/20 in both eyes. There was minimal residual esotropia with no significant functional impairment. Dr. Frayer stated that he had studied Appendix 1, Subpart P, and concluded that the claimant had no impairment listed in that Appendix (Exhibit 56).

At the request of the undersigned, Dr. Tim Lachman, a neurologist, evaluated the claimant on March 14, 1983. The claimant had a history of a seizure disorder with two seizure episodes. There had been no seizures in about two years. The claimant was described as alert and cooperative. There were a few beats of nystagmus at the end of horizontal gaze to either side. Neurologic examination was otherwise normal. Dr. Lachman's impression was generalized, tonic-clonic seizure disorder, presently under good control (Exhibit 59).

Dr. Joseph Puleo, a psychologist, evaluated the claimant on March 23, 1983, also at the request of the undersigned. He administered a Wechsler intelligence test on which the claimant achieved a full scale IQ of 64, verbal IQ of 67 and performance IQ of 65. WRAT revealed a grade level of 1.4 in reading and 2.4 in arithmetic. Rorschach revealed emotional immaturity and intellectual and social impoverishment consistent with a developmental delay of two years. Rorschach was also consistent with significant latent anxiety. Dr. Puleo's impressions were developmental learning disorder, minimal brain dysfunction and mild mental retardation (Exhibit 60).

At the further request of the undersigned, Dr. John Goppelt, a psychiatrist, examined the claimant on March 25, 1983. The claimant's intelligence seemed somewhat below average but Dr. Goppelt found no evidence of a psychiatric disorder (Exhibit 61).

Interrogatories and a copy of the evidence of record were submitted by the undersigned to Dr. Margaret Friel who is a psychiatrist and a medical advisor to the Social Security Administration. Dr. Friel reviewed the evidence and concluded that the claimant had no impairment described in Appendix 1, Subpart P, Regulations No. 4, nor any impairment or combination of impairments of equivalent severity (Exhibit 62).

Interrogatories and a copy of the record were also submitted by the undersigned to Dr. Gunter Haase, a neurologist and medical advisor to the Social Security Administration. Dr. Haase reviewed the evidence and concluded the claimant had no impairment or combination of impairments which met or equalled the impairments listed in Appendix 1, Subpart P (Exhibit 64).

A hearing had been held in Philadelphia, Pennsylvania on February 16, 1983. The claimant, to the undersigned, appeared friendly and cooperative. She interacted in an open manner. She named her favorite television program and mentioned several household chores which she performs. The applicant testified that the claimant bathes and dresses herself. She said that the claimant occasionally has a temper tantrum.

The claimant, who is eight years old, of course has not been engaging in substantial gainful activity. She has a severe impairment in the form of mild mental retardation. In order to be eligible for supplemental security income, she must have an impairment described in Appendix 1, Subpart P, Regulations No. 4, or an impairment or combination of impairments of equivalent severity.

The section the Appendix applicable to this case is section 112.05 which deals with mental retardation. A child meets that section if she has an IQ of 59 or less or an IQ of 60-69 and a physical or other mental impairment imposing additional and significant restriction of function or developmental progression. The claimant's IQ, based on the latest psychological evaluation, falls in the 60-69 range. However, the evidence does not establish that she has a significant impairment other than her mild mental retardation. Her congenital strabismus has been surgically corrected. She has no significant sensory impairment. Her seizure disorder is well controlled on medication. She has had no seizure in more than two years. Accordingly, the undersigned concludes that the claimant's condition is not as described in section 112.05, Appendix 1. The claimant likewise does not have an impairment or combination of impairments of equivalent severity. These conclusions are supported by the views of Drs. Friel and Haase which are summarized above.

Dr. Barrer examined the claimant on October 5, 1981. His neurologic examination was negative. At that time it was clear that the claimant's seizure disorder was well controlled and her intellectual functioning had improved. A conclusion that the claimant was no longer disabled as of October 5, 1981, would thus be reasonable. However, it is the policy of the Social Security Administration, subject to exceptions which are inapplicable to this case, that disability will not be found to have ceased prior to the month in which notice of planned cessation is provided. In this case that month was November 1981. Accordingly, the undersigned finds that the claimant's disability is deemed to have ceased in November 1981.

Claimant's representative has raised the issue of whether the regulatory provisions requiring the claimant to meet or equal the impairments in Appendix 1 are unlawfully more restrictive than intended by Congress. The Social Security Regulations are binding on the undersigned who has no jurisdiction to declare them invalid. Challenges to such regulations must be raised in a more appropriate forum.

FINDINGS

After careful consideration of the entire record, the Administrative Law Judge makes the following findings:

1. The claimant was found to be disabled within the meaning of the Social Security Act as of August 13, 1979.
2. The claimant's impairment is mild mental retardation.
3. The claimant has not engaged in substantial gainful activity since becoming eligible for supplemental security income.

4. The medical evidence establishes that since November 1981, the claimant has not had an impairment or combination of impairments listed in or medically equal to one listed in Appendix 1, Subpart P, Regulations No. 4 (20 CFR 416.925 and 416.926).
5. The claimant's disability ceased on November 1981 (20 CFR 416.994(c)).

DECISION

It is the decision of the Administrative Law Judge that the claimant's eligibility for supplemental security income under sections 1602 and 1614(a)(3)(A) of the Social Security Act, ended effective January 31, 1982, the end of the second calendar month after the month in which the disability ceased.

/s/ Malvin B. Eisenberg
 MALVIN B. EISENBERG
 Administrative Law Judge

July 27, 1983
 Date

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 83-3314

BRIAN ZEBLEY, ET AL., PLAINTIFFS

VS.

MARGARET HECKLER, ET AL., DEFENDANTS

DEPOSITION OF: BERTRAND KUSHNER, M.D.
 TAKEN BY: PLAINTIFFS
 DATE: JULY 20, 1984, 9:30 A.M.

APPEARANCES:

DELAWARE COUNTY LEGAL ASSISTANCE
 ASSOCIATION
 BY: MARK KAUFMAN, ESQUIRE
 FOR - PLAINTIFFS
 JOHN E. NEWTON, JR., ESQUIRE
 FOR - DEFENDANTS

[2] BERTRAND KUSHNER, M.D., called as a witness, being sworn, testified as follows:

DIRECT EXAMINATION

BY MR. KAUFMAN:

- Q. State your name for the record.
- A. Bertrand Kushner, Dr. Bertrand Kushner.
- Q. And you are a physician; is that correct?
- A. Correct.

Q. A medical doctor?

A. Correct.

Q. Do you have any particular specialty?

A. Internal medicine and gastroenterology.

Q. And perhaps you can just briefly describe your background education and career.

A. University of Pennsylvania undergraduate, Jefferson Medical College, internship at Albert Einstein Southern Division of Philadelphia. Residency, Jefferson Medical College Hospital. In practice in Harrisburg since 1960.

Q. That is a private practice?

A. My private practice.

Q. And, what is your position if any with disability determinations?

A. I have been a reviewing physician for disability since 1962.

. * * * *

[21] Q. My question was, the statement was that they were impairments which were not "severe", they were nonetheless impairments and there were a multitude of them in addition to the IQ but none of them were singularly severe.

A. This would not meet the listing.

Q. I'd like to talk briefly a bit about then, since you have a listing in front of you, 112.04 of the listing.

A. Functional nonpsychotic disorders.

Q. Yes, that's correct.

Now, I believe it was your testimony earlier that each and every element of a listing must be met; is that correct?

A. That's correct.

Q. In the opening paragraph of that subsection 112.04, it states in part: "Marked restriction in the performance of daily age appropriate activities, constriction of age appropriate interests, deficiency of age appropriate self care skills and impaired ability to relate to others."

Must the medical evidence document marked restrictions in each of those categories?

A. Yes.

Q. So that a marked restriction in several of those [22] categories with restrictions that are not "marked" in other categories would not meet the listing?

A. Would have to meet every one of them, yes.

Q. What is a marked restriction in distinction from a restriction?

A. That's a judgment based on the—that is a judgment that a physician would have to make based on the evidence.

Q. Is there any standard schedule, scheme, rule for evaluating where a restriction becomes marked and when it is less than marked?

A. I don't know of any.

Q. I would like to just come back briefly again to this notion of equivalence, which is slippery—at least my brain has difficulty coping with it. Unfortunately, the example we imposed you said there was no need for the notion of equivalency because there was a listing; is that correct?

A. Yes.

Q. Assuming that we have a child with a functional nonpsychotic disorder with marked restrictions in their age appropriate activities and interests, inability to relate to others, impairments of their self care skills but somehow less than marked so that it doesn't meet the listed impairment; is that correct?

A. Correct.

Q. Who in addition had the orthopedic problem you described for our hypothetical child, John Doe. Can you using that or those givens, describe how the concept of equivalence would or would not work in such a case?

A. Equivalence really—I think you are trying to equate—or you sound like you are trying to equate equivalence with combination.

Q. Maybe I was trying to do that.

A. Two different things. That's not my concept. That is not the concept I have of equivalence. The concept I have of equivalence is that the medical problem is severe as the listings describe but there is no listing to fit it into. The listings, as far as I can determine, do not cover a hundred percent of medical problems. There has to be some medical problem that is going to come up that doesn't fit in any of the categories we have. And if we determine it is as bad as one of these listing but we don't have a listing for it, then we would say it is equivalent to. A combination and equivalence are not the same.

Q. So in this hypothetical I gave you, equivalence is not an appropriate concept, but a combination is; is that correct?

A. Right.

Q. Let's move on then to this concept of combination. Can you describe to me—

A. There is no—we have no listing of severity or [24] medical impairment that includes a combination other than when they are actually described in the listing itself as that one case was.

Q. So in a case such as that, how would you deal with that?

A. We would say it does not meet the listings.

Q. And that equivalence—it does not equal the listing?

A. Did not equal the listing.

Q. Another question in regard to combination. Am I correct in my understanding that no combination of impairments, regardless of the number and variety of impairments which—none of which are themselves severe impair-

ments can be utilized to meet or equal the listed impairments; is that correct?

A. In general, it's correct. There are some specific cases where there may be two impairments neither of which meet the listings but one impacts so much on the other that it may equal what we would consider equal the listings. These are very rare, I would say, unusual-type cases.

Q. Can you give me some sense of how much or how frequently the concept of equivalent is applied in cases of mental disability?

A. I would say it would be unusual to have a mental claim adjudicated as equaling the listings.

Q. And again, can you give me some sense of—apart [25] from cases involving mental retardation under subsection C of 1205 and 11205, the frequency with which combinations of impairment are employed in meeting or equaling the listing?

A. It would be very unusual.

Q. In both cases of children or adults?

A. Correct.

Q. Now, to what extent can you substitute the severity of a particular symptomology or clinical finding for the failure of the medical evidence to document meeting each and every aspect of a listing?

A. In order to meet the listing, they have to meet each and every aspect.

Q. So your answer to my question would be that you can't?

A. Can't.

Q. If I recall, I started out the last line of questioning talking about adults and we shifted back and forth between adults but it had been your testimony that the concept of meeting and equaling was the same for adults and

children with regard to this phase of the evaluation disability; is that correct?

A. That's correct.

Q. Are there differences between children and adults in terms of this concept of combination of impairment at this stage of the evaluation?

[26] A. No.

Q. Just to clarify some things in my mind, I would like to move beyond a bit of the listing notions. Assuming an adult does not meet or equal a listed impairment, there is further evaluation; is that correct?

A. Yes.

Q. And, can you describe that further evaluation?

A. Well, as far as the medical — as far as the physicians are concerned, we must determine what we call residual functional capacity, which is a description of what that person's capable of doing.

Q. And may I take it by implication then that an individual who does not meet or equal a listed impairment is ipso facto capable of doing something?

A. Capable of doing something? I guess I can agree. Capable of doing something.

Q. Although he may or may not be capable of working?

A. Correct.

Q. Depending on how much of something he can do or she can do.

Now, in the context of doing this residual functional capacity analysis, you were again considering then the medical evidence; is that correct?

A. Based on the medical evidence.

Q. In the context of doing that analysis, can you con-[27]sider the particular severity of certain clinical findings or symptomology even though not all the elements of a listed impairment are met?

A. Exactly what we do.

Q. And conclude that the individual cannot be expected to work?

A. No. Physicians don't make that decision.

Q. I am sorry. The physician would —

A. Determine what the person is medically capable, medically capable of doing.

Q. Which could be quite limited?

A. Could be.

Q. Now, in the context of doing the residual functional capacity analysis from the physician's standpoint to determine what the individual's medically capable of doing, can you combine the impairment that we had previously described —

A. Use all the medical you have to reach that — whatever conclusion you reach based on all the medical facts in the case.

Q. So that when I asked you — when you testified that — earlier that combinations of impairments were not frequently employed in the context of mental disability claims other than the mental retardation claim, would it be your testimony that they are frequently employed under the —

[28] A. If there's more than one medical problem, then it's considered in determining RFC, certainly.

Q. And you testified that no combination of impairments, whatever multitude, none of which were themselves severe could lead to the meeting or equaling listed impairment ordinarily; is that correct?

A. That's correct.

Q. Would you consider those impairments in the context of discerning what the individual could do residually?

A. Well, if you are saying they are not severe by definition, they don't impact on his residual function. If you are talking about non severe impairments, even if

there are 20 of them, they would not impact on residual functional capacity. By definition we are saying that a non severe impairment does not —

Q. Would you consider impairment that in your medical judgment some of which you believe were severe and some of which you believed were not severe in combination with each other?

A. Well, we considered the severe impairments.

Q. Only the severe impairments?

A. Only the severe impairments.

Q. May I take it then that in the case of an adult who tested an IQ of, say, 70 and have had the orthopedic problems you previously described related to the child, John Doe —

[29] A. An adult with those?

Q. An adult with those problems would not meet the listed impairment?

A. I would — I would say would not meet the listed impairment.

Q. And the concept of equivalence again would not be applicable?

A. Correct.

Q. But that the combination of those impairments would be considered by the medical staff with a view to determining what remaining work — what remaining activities the individual medically could be expected to do?

A. Well, I really have to have a better description of the orthopedic problem before, you know, before —

Q. I am not asking you for an opinion on what the person — but you would consider it to determine what they could do?

A. If the orthopedic problem was considered severe, it would be involved in the determination of RFC.

Q. And at least hypothetically the orthopedic problem together with the IQ could be severe enough to restrict that individual's activities very greatly?

A. Could be.

Q. Now, in the case of a child with that combination, IQ of 70 rather than 64 but otherwise the same, that child [30] would not meet the listed impairment?

A. They would not meet the listed.

Q. And again, the concept of equivalency would not place?

A. No.

Q. Assuming for the moment that the orthopedic problem was a severe problem, where if at all would there be consideration of the combination of those impairments for that child?

A. With an IQ of?

Q. 70.

A. It would not meet the list.

Q. And there would be no consideration, therefore, for that combination?

A. We don't determine residual functional capacity on children.

* * * * *

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

NO. 83-3314

BRIAN ZEBLEY, ET AL., PLAINTIFFS

vs.

MARGARET HECKLER, SECRETARY OF HEALTH
AND HUMAN SERVICES, DEFENDANT

Oral deposition of MAURICE PROUT, Ph.D., taken on behalf of the Plaintiffs, in the Law Office of JOHN NEWTON, ESQUIRE, 3535 Market Street, Philadelphia, Pennsylvania, on Thursday, July 19, 1984, commencing at or about 1:45 P.M., before Lorraine D. Connell, Registered Professional Reporter-Notary Public.

[6] * * * * *

I've been at Hahnemann University Medical School in the Department of Psychiatry since 1975 to present on a full time basis.

I am an adjunct professor at the University of Pennsylvania in the Department of Psychiatry.

Q. And, what is your position here with Social Security?

A. As a consultant.

* * * * *

A. I've been doing it for seven years.

* * * * *

[9] Q. Can you briefly describe what those duties are?

A. Sure.

What we do is look at cases that come in on a second tier review, and we make a [10] decision on whether those cases have been adjudicated properly, in terms of what was done on what is referred to as a first tier review.

This is done on a sample basis, and, again, you know, there would be times when a case has been, for instance, allowed, and we make a determination that the case should not have been allowed, that the judgment was in error, or where a case was denied, and we make a determination that the evidence indeed supports an allowance, or, the third option would be when a decision has been made either to allow or disallow the case, and we decide that the medical evidence is not substantial enough to render a decision.

Q. Are these part of some regular quality review program?

A. Right.

* * * * *

[17] In terms of the concept of meeting or equaling a listed impairment, is there any difference between the evaluation of children and adults?

A. No, there isn't.

Q. So, we can safely assume that when we talk about what those concepts mean, and the kinds of evidence that are included, that it is true of both adults and children?

A. Sure.

I should also point out that with regard to the equals concept, it is hardly ever utilized in mental cases.

Q. I was about to get to that.

A. Sure.

Q. But, maybe we'll just put that off for a moment, and come back to that.

A. Okay.

Q. Can you tell me what meeting a listed impairment means?

A. Sure.

Q. What is that?

A. It depends on what the impairment is, and in the case of the twelve hundred categories, for instance, as it's germane to this particular case—

* * * * *

[23] Q. Now, in that scheme of determining whether someone meets a listed impairment, suppose that although each and every element was not met, the level of impairment with regard to the other elements was by any medical or lay standard that you would care to name, very severe, does the concept of meeting, just the concept of meeting a listed impairment, have a means for allowing for particular severity of certain restrictions?

A. No.

I think the law is quite clear as it is stated.

In order to meet a listing, these are the criteria.

* * * * *

[27] A. The concept would be that the evidence doesn't meet a listing, but there's a combination of maladies or disabilities that the individual has, and in combination, someone makes a determination that, indeed, it's severe enough to equal the intent of the listing.

Again, it's rare that it's utilized in the mental categories.

I understand that it's much more frequent in cardiac cases, orthopedic cases and the rest of it.

It will be utilized in the mental listings contingent on when you use the P.R.F. form, that you have a constellation of three in effective intelligence, three in affective disturbance and a three in reality context.

The three and the three and the three won't meet anything, since the individual is not severely impaired in intellectual function, he's not severely impaired in affective function—I shouldn't say that, I'm sorry.

Let me correct myself.

He is severely impaired.

Doesn't meet the concept, but clearly when you put all of this material together, [28] the individual overall is severely impaired, and the concept would be with the three and the three and three constellation that he equals the intent listing.

That's the only time that you'll get an equals on a mental case.

Q. I see.

So, with regard to the mental retardation sections—

A. (Interposing) the 1205 instance?

Q. The 1205 instance and the one hundred and 1205 instance, the individual with an IQ between sixty and sixty-nine, however functionally impaired they might be, either does or doesn't have a significant other restriction of function, and there's no room for equivalence; is that what you're saying?

A. That's quite correct.

Q. I'd like to talk about that a little bit more, that phrase other.

It's phrased slightly different, if I recall correctly, between the adult and the child listing.

You might refer to those.

* * * * *

[35] Q. So, the problem would be true of children as well?

A. Sure.

Q. Does it go the other way around as well?

You've said that, if I understood you correctly, that distinguishing poor performance because of mental retardation from a poor performance because of a functional disorder like an affected disorder, depressive disorder, can be difficult, can I then safely assume that the distinguishing—

A. (Interposing) I don't think that it's difficult. I think you have to be clinically astute. I don't think it's difficult.

Q. I guess my question was really trying to come at it from the other way.

Assuming you had a child who you accept as, in fact, being mentally retarded with conduct and behavior problems, depression—

A. (Interposing) yes.

Q. —how do you go about distinguishing whether that is an other quote other functional limitation, [36] or whether it's really just a part of the mental retardation?

A. It becomes more difficult to do it with children than with adults.

You don't have a large store of premorbid history with children.

The brain, for the most part, isn't fully functional with kids in terms of being able to absorb a variety of experiences and function in a variety of capacities.

What you may be picking up is a developmental lag, for instance, in a kid who four years from now will show up with a normal IQ.

But, that is not what you're picking up initially.

Or, what you may pick up is something like an adjustment disorder in childhood.

What is the divorce rate these days, about fifty percent in the United States.

All kids, I would guarantee, go through a period of time, and they may indeed be—let's take a kid who's five

years old, who was previously toilet trained, for instance.

* * * * *

[55] Q. And, I asked you if a particular severity in one aspect of their mental condition could be considered with a view towards whether they met the listing—

A. (Interposing) correct.

Q. And, I believe your answer to that question was no—

A. (Interposing) right.

Q. Okay.

Taking that sequence of thoughts one step further, can the particular severity of a particular aspect of the mental disorder, in a case which did not meet the listing because it failed the requisite level of severity of some other aspect of the listing, be taken into account in determining equivalence?

A. No.

Again, we're talking about the mental listings.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 83-3314

BRIAN ZEBLEY, ET AL., PLAINTIFFS

—
vs.

MARGARET M. HECKLER SECRETARY OF HEALTH
AND HUMAN SERVICES, DEFENDANT

Deposition of JEROME E. SHAPIRO, M.D., taken on Friday, August 10, 1984, at 2:00 p.m., at the Social Security Administration, Dickinson Building, 1500 Woodlawn Drive, Woodlawn, Maryland, before Diane D'Argenio, Notary Public.

* * * * *

[2] STIPULATION

It is stipulated and agreed by and between counsel for the respective parties that the filing of this deposition with the Clerk of Court is hereby waived.

JEROME E. SHAPIRO, M.D.,

Q. Why don't you state your name and address for the record.

A. My name is Dr. Jerome E. Shapiro, 5725 Ridgedale Road, Baltimore, Maryland, 21209, my home address. One East University Parkway, No. 110, Baltimore, Maryland, 21218 is my office address.

Q. We're here on a deposition which is just part of what's called the discovery process of law, and I suppose it's called a discovery process because that's what I'm trying to do, just learn something about how the agency approaches the issue of evaluating medical evidence in child cases. I don't come here with any [3] particular ax, in a sense of precommitment to any particular answer. It's just an opportunity for you to tell me from your experience how the agency functions. In order to do that, I want to make sure that we have a very clear record so that if at any time you decide that the answer wasn't complete enough or was misleading in some fashion, just interrupt and correct it. The point here is to get as clear a record of what the agency is doing as possible, not to judge or evaluate, but that's up to the Court rather than to either me or counsel for the agency. Also, if in the course of asking a question I have somehow misstated a rule or misstated your understanding of something that you had said, please correct me on that, too. I've certainly been known to do that on occasion. I don't mind being corrected.

Can you tell me what your current position here with Social Security is?

A. My current position is as a part-time contract psychiatric consultant to the medical consultant staff of the disability program, the Office of Disability, and in that capacity, I have worked with the agency for [4] approximately 20 years. My specialty is psychiatry, and so my expertise, if we want to call it that, is in the area of assessing psychiatric impairments in disability applicants. Not in determining disability, but in assessing a medical, a psychiatric impairment. I specify that—if I may amplify just a little.

Q. Please do.

A. I specify that because there is often some confusion about the term disability as opposed to the term impair-

ment, and I want to state clearly that the two are not synonymous, that the term disability involves other factors besides medical factors, whereas impairment implies a medical judgment about severity of a particular condition.

Q. So your task is to advise the agency with regard to the issue of impairment as a medical issue rather than the issue of disability?

A. Correct.

Q. Can you perhaps describe the kinds of matters you're asked to consult with the agency on?

A. We get a variety of cases in the medical [5] consultant staff beginning, of course, at the state agency level, sometimes progressing through the regional level, and then to the central office, so that one function is to provide a quality review of assessments performed by consultants in the regional offices and in the state agency offices.

We also, of course, get cases from abroad from applicants who have worked in the United States and who have gone abroad and who are applying for disability, foreign claims. That is, we get certain disagreements between state agencies and regional offices and make an attempt to resolve those disagreements, so that we have a variety of cases, and this is the kind of work that I do.

I also do some peer review in the office in terms of assessing work done by my colleagues.

Q. When you say disagreement between state agencies, do you mean over matters of policy or about a particular case?

A. Only medical matters. In my case, psychiatric matters. In terms of severity of a condition.

* * * * *

[42] Q. Well, just let's exclude the mental retardation issue with regard to other kinds of behavioral disturbances such as personality, nonpsychotic disorders. Have you en-

countered those unable to function in structured kinds of settings but, left to their own devices, passably manage?

A. I'm a little confused about the question. Maybe you could put it to me again.

Q. Let me give you an example: A child with a conduct of behavior and disturbance severe enough that [43] he's unable to get along with his peers in the school setting, unable to follow the instructions of the teacher, unwilling to follow the instructions of the teacher. On home bound instruction because he's sufficiently disruptive in a classroom setting, he's limited there, isolated and withdrawn in many respects from his peers in the neighborhood, but who brushes his teeth and takes care of himself more or less, and whose parents, for whatever reason, kind of leave him on his own to set his own schedules, so within that context functions fairly well. Would you visualize that picture I have drawn as being unacceptable or unrealistic or —

A. Well, that situation occurs fairly often. Whether that kind of a situation represents a condition that meets or equals a child listing is another question.

Q. Obviously. Taking the same kind of a situation with an adult, because of a severe personality disorder or something, he is forever telling his boss to take the job and shove it and has difficulty getting along with his spouse and just generalized difficulty getting along with anyone or following instructions, he's been fired a [44] dozen times or quit a dozen times immediately before being fired and had some run-ins with the law here and there because he can't avoid telling the police officer what the police officer should do with himself, but again on his own, sitting around the table and carrying on with friends of like mind and making his own peanut butter and jelly sandwiches or working on the car out in the backyard, does okay. Do you see that as being an unrealistic pattern?

A. Well, again, it's a pattern that occurs pretty often, and the question about whether it meets or equals a listing depends on, you know, many many factors. As a clinician, I would be inclined in assessing someone like like that, I would be inclined to expect more from someone who has a high IQ than from someone who has a low IQ.

Q. Certainly.

A. And I think in terms of making a judgment about severity of impairment, if somebody had an IQ of 60 and was carrying on like that, I might feel that he had in addition a personality disorder substantial enough so [45] that he would meet listing 12.05 C.

Q. For example.

A. And the same with a child.

Q. Absolutely. So you said, if I'm correct, that either this adult or child could well not meet or equal the listed impairment?

A. That's possible, yes.

Q. And yet, as I described it, isn't it difficult to conceive of the adult working?

A. In some cases, yes.

Q. And the—

A. In some cases, yes, but I have to qualify it by saying he still might not meet or equal the listing, even though my gut feeling is that this is a loser and he'll never hold a job.

Q. Some are my clients.

A. But he still might not meet or equal the listing.

Q. A consideration of the extent of his medical limitations, and what remains of the functional capacity, would then take place further down in the sequential [46] evaluation and might lead to the conclusion that he was disabled, in the case of an adult?

A. Yes.

Q. And in the case of a child, if a determination was made that the child did not meet or equal the listed impairment, the child would be of the identical functional symptomatology, that would be the end of the evaluation?

A. True. Let me point out that my feeling about comparing the adult listings, which are then subject to a residual functional capacity assessment, the RFC, with the child listings, for which there is no provision because either the child meets or equals or he does not, and there is no provision for an RFC, that the child listings by and large do specify the kinds of areas that are covered in the RFC in child terms by constantly referring to age appropriate activities and interests and ability to relate to others. So that the items in the RFC which would apply to an adult who would be expected to work, don't correspond one for one with the child listings, but many of them are incorporated * * *

* * * * *

[50] Q. So in the context of children, feeling the way you have about adults, there's even less point in an RFC, but if there was point for either, would that be a correct assessment?

A. Yes, I think so. This is personal opinion, I divorce myself at this point from any policy, but I certainly feel that it has little place in the assessment of children to use that. Now, again, I'm not—I'm bound by the regulations which—

Q. I understand.

A. —really present an either/or situation. Not in my medical assessment. My medical assessment is going to be the same type of rating as for adults, but I know inside that the implications are that if this child does not meet or equal the listings that he will be found not disabled.

Q. Whereas an adult with an identical medical [51] impression could well be found disabled?

A. Yes, but that is not a medical judgment at that point.

MR. KAUFMAN: I don't think I have any further questions.

MR. IMPERATO: Mark, could we recess for a few minutes and see if we have any additional questions?

MR. KAUFMAN: Sure. No problem. I'm sorry, I did have one tiny final question just to tie up the record.

Q. I was given a curriculum vitae of yours. Is that a correct description of your background?

A. That is a correct description of past and current professional activities.

DEPARTMENT OF
HEALTH, EDUCATION AND WELFARE
Social Security Administration

September 7, 1973

SSA DISABILITY INSURANCE LETTER NO III-11

* * * * *

IV. Evaluation of Childhood Disability

A. General

With the implementation of the SSI program, the Social Security Administration will, for the first time, be responsible for evaluating disability in children who are under the age of 18. Moreover, there is no organization known to exist either within or outside the Federal government which has a large scale program involving this type of childhood disability evaluation. (The childhood disability provisions of title II, of course, relate to adults who became disabled prior to the age of 22.)

Evaluation criteria, therefore, will be based on a combination of two factors: (1) experience drawn from the title II disability program insofar as it may relate to children; and (2) expertise provided by medical authorities, particularly by experts in the field of childhood diseases and impairments.

B. Evaluation Considerations

1. *Meaning of Childhood Disability*

Within the context of the basic definition of disability (i.e., an inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental im-

pairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than (twelve months), title XVI provides for a finding of disability in the case of a child under the age of 18 (who is neither married nor the head of a household) if he suffers from any medically determinable physical or mental impairment of "comparable severity."

In considering the application of this provision, it is necessary to define how the ability to function in primary activities appropriate for adults and children may be determined. Historically, the term "disability" has, under title II, been associated exclusively with an inability to work, which is a primary activity of adults. This term, when applied to children, cannot properly be associated with an inability to work, since children are not ordinarily expected to engage in such activity. Accordingly, disability in children must be defined in terms of the primary activity in which they engage, namely growth and development, the process of maturation. Additionally, children even with the same diagnosed disease as an adult, may have different pathophysiologic manifestations of that disease, and the impact of the disease may be quite different. Also, some children will receive traumatic impairments (e.g., the loss of two limbs) which will be the basis for a finding of disability.

These factors make it impossible to compare directly the severity of the child's impairment

with that of an impairment which would prevent an adult from engaging in SGA; thus, in applying the guides, "comparable severity" means that the severity of the impact of the child's impairment(s) must be "comparable" to the severity of the impact of an impairment(s) which would prevent an adult from engaging in any substantial gainful activity. In applying this concept to adjudication, childhood disability will be determined solely in consideration of medical factors. (We are developing additional medical evaluation guides which will provide the detailed findings for use in adjudicating childhood cases.)

2. *Evidence of Childhood Disability*

Medical evidence sufficient to permit an independent determination of disability will be required. Descriptions of a child's activities, behavioral adjustment, and school achievement may be considered in relationship to the overall medical history regarding severity of the impairment.

3. *Vocational Factors*

Vocational factors *will not* be considered in the evaluation of childhood disability. The application of such factors would be inappropriate since the primary activities of children are not generally measured in vocational terms. As previously indicated, work is not a primary activity of children and most individuals in this age category are unemployed. In any event, incidental or casual employment

in which a child might engage would not generally have vocational relevance.

4. *Level of Impairment Severity*

The Listing of Impairments which is used to evaluate title II disability claims solely in consideration of medical factors, will also be utilized to the extent feasible in evaluating title XVI childhood applications.

It is recognized, however, that while some of the existing listings are appropriate for use in evaluating diseases and impairments in children, others are totally inapplicable. Accordingly, guides for determining which of the present title II listings are applicable to children and which are not will be issued separately. In addition, totally new evaluation criteria to be used exclusively with childhood applications are now being developed and will be issued separately.

The guides pertaining to the applicability of the existing title II listings to children, as well as the new childhood evaluation criteria, are to be used to evaluate childhood applications for an interim period of time; during this time our experience with the guides will be carefully analyzed. Permanent evaluation criteria will be formally issued at a later date.

NOTE: The principle of medical equivalence, as outlined in § 404.1505 of the title II regulations, and as detailed in the DIL III-8 Supplement (§ II.E), is fully applicable even though permanent guides have not yet been issued.

5. *Substantial Gainful Activity*

Consonant with overall title XVI disability criteria, any SGA issue which arises with respect to a child will be handled in accordance with the guides provided in § III.E above.

6. *Onset and Cessation Prior to Adjudication*

The criteria for establishing onset and for determining disability which ceased prior to adjudication will be the same for children as for adults under title XVI. (See § III.B.)

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DEPARTMENT OF
HEALTH EDUCATION AND WELFARE
Social Security Administration

January 9, 1974

SSA DISABILITY INSURANCE LETTER NO III-11 -
Supplement 1

(To be filed following DIL III-11 at the end of Part III of
the Disability Insurance State Manual)

Subject: Evaluation of Child Claims Filed Under the
Supplemental Security Income Provisions of
the 1972 Amendments (Public Law 92-603)

* * * * *

I. PURPOSE OF ISSUANCE

This supplement to DIL III-11 discusses general evaluation concepts for child claims under title XVI, the usefulness of the title II "adult" listing is evaluating these claims, and the evaluation of several specific childhood impairments which, as you know, must meet or be equivalent to the severity of the listed impairments to establish disability.

II. BACKGROUND

DIL III-11, Section IV, provides general guides for the evaluation of child claims. As discussed therein, the concept of inability to engage in SGA is not relevant for children under the age of 18. This will undoubtedly require development of suitable supplements to existing criteria in the Listing of Impairments. The uniqueness of the provisions applicable to children and the absence of any existing child programs from which appropriate criteria can be adopted will necessitate considerable experience in adjudication before criteria can be established.

Section 1614(a)(3)(A) of the Social Security Act, as provided by § 301 of Public Law 92-603, permits payment of benefits to "a child under age 18, if he suffers from any medically determinable physical or mental impairment of comparable severity" to that which shall be considered disabling for an adult. Subpart I of Regulations No. 16 (as currently proposed) specifically requires that a child's impairment or impairments must either *meet* or *equal* the listing of impairments which will be published in an appendix to that subpart. (That listing is practically identical to the listing used in the title II program, the appendix to subpart P of Regulations No. 4.) It is expected that some claims will involve childhood diseases or manifestations of disease, which are not adequately described by the appendix and which, therefore, do not "meet" the requirements of the appendix listing. Until a separate listing can be included in the Regulations of childhood impairments "of comparable severity" to adult impairments, it will be necessary to apply standards described in this supplement and future supplements in evaluating claims where the child's impairment may "equal" rather than "meet" the current adult listing.

This supplement is designed, therefore, to be used by the SA in determining whether or not the severity of the child's impairment is medically the equivalent to a currently listed impairment. Later, as experience is gained and supplemental criteria for evaluating child claims are developed, they will be published in the regulations.

III. THE CONCEPT OF COMPARABLE SEVERITY

The provisions applicable to children will require not only the development of additional, more specific criteria, but also a definition of the phrase "impairment of comparable severity." It is evident that an impairment of com-

parable severity in a child cannot be judged on the same basis as an impairment which prevents an adult from engaging in substantial gainful activity, since children are not expected to so engage. Moreover, children should not be considered as "little adults." Children, even with the same diagnosed disease as an adult, may have different pathophysiologic manifestations of that disease and the impact on the child of impairment from the disease may be different. Children may be said to engage in the process of growth and development, this is, the process of maturation. Specifically, this involves (1) growth— increase in size and maturation of physical and functional characteristics, (2) learning, (3) mastering basic skills, and (4) emotional and social development. In defining "comparable severity," therefore, we attempt to describe childhood impairments which interfere with maturation to the same extent as the adult medical criteria describe adult impairments which prevent substantial gainful activity. The factors to be compared are the *impact* of the child's impairment on the child's life and the impact of the adult's impairment on the adult's life.

IV. EVALUATING CHILD CLAIMS

The medical criteria (Listing of Impairments) in the Appendix to Subpart P, Regulations No. 4, (virtually the same as the listing in the appendix to proposed Subpart I of Regulations No. 16), have been reviewed to assess their usefulness for evaluation of childhood impairments. A section of this material provides a tabulation of the listing subsections, with a comment on such usefulness. (See *Exhibit 1*.) Also provided as part of this material (see *Exhibit 2*) are childhood impairment guides; this list will be expanded in the future as experience dictates. These materials have evolved from discussion based on program

experience in dealing with claims involving adult impairments. They are intended primarily to provide guidance in determining whether or not a child's impairment is equivalent in severity to a listed impairment. Exhibit 2 describes impairments, the impact of which will interfere with the child's major activities (i.e., growth and development) to the same extent as the impact of the impairments listed in the adult criteria interfere with the adult's ability to engage in substantial gainful activity.

V. MEDICAL EQUIVALENCY CONCEPT

Case adjudication, particularly until the medical guides for evaluating child claims are adequately refined, will depend heavily on the proper use of a "medical equivalency" concept which takes into account the particular effect of disease processes in childhood. In addition to the need for adjudicating under the "equals" concept where none of the adult listings can be applied, consideration must be given to the combined effect of multiple impairments, each of which, singly, is short of the listings. Exhibit 2 lists such combinations of impairments that are frequently seen together (e.g., C111.02, C111.07) without specifying a severity level for the individual impairments. Each impairment must have some substantial adverse effect on the child's major daily activities, and together must "equal" the specified impact. It must be understood that each impairment to be so considered in the combination would, of necessity, not "meet" or "equal" the requirements alone, but must represent more than a slight or mild impairment.

VI. ADVERSE FACTORS OF LEARNING AND BEHAVIOR

Not all children's impairments will lend themselves to formal codification. We are aware that a significant number of children are impaired in their intellectual, social,

and emotional developmental progression by problems of learning and/or behavior. These conditions may be ill-defined and imperfectly understood. Diagnostic criteria are not universally agreed upon. They include such phenomena as perceptual handicaps, dyslexia, hyperactivity, minimal cerebral dysfunction, distractability, poor self-concept, emotional lability, etc. At the present time, specific anatomic, physiologic, or psychologic abnormalities are not unequivocally demonstrable by medically acceptable clinical and laboratory diagnostic techniques. They are not severe enough to cause the requisite level of impairment severity in and of themselves, but may act as adverse factors when another medically determinable impairment exists. Medical, psychological, and/or educational diagnostic techniques that have been performed on these children should, therefore, be requested, along with references delineating standardization and validity of less widely known procedures. In this way, traditionally medically determinable impairments complicated by problems of learning and/or behavior may be more effectively adjudicated.

VII. DEVELOPMENTAL MILESTONES

A compilation of data on "developmental milestones" is being prepared which indicates the ages at which the average healthy child generally acquires new skills and proficiencies in the areas of social, intellectual, and physical development. This information is designed primarily for assessment of impairments involving abnormal or retarded growth and development occurring either as a primary impairment or secondary to another physical or mental impairment. Medical evaluation discussion is based upon evidence which adequately describes the child's growth and development. In the near future, it is

expected that in specified cases a short questionnaire on the most evident of the growth and development factors will be completed in the district office. This information will be useful for screening certain types of applicants and for deciding whether additional evidence is necessary, but the questionnaire alone will not provide sufficient probative evidence for impairment assessment.

VIII. SCHOOL ATTENDANCE

Attendance at school, even if full-time or in the proper grade, should not be considered to rule out the presence of a severe impairment. Conversely, absence from school or poor performance at school does not represent a factor which can be used to properly determine the presence of an impairment. It is necessary to evaluate the impairment which interferes with these events.

IX. QUESTIONS AND COMMENTS REQUESTED

It is important that State agencies provide comments concerning the usefulness of this issuance and the published criteria in adjudicating childhood claims. These comments may be made in a number of ways, as best suits the procedure in the State agency, but should include: (1) statements made directly on cases which should be sent to BDI after adjudication and any necessary post adjudication review (e.g., in the Claims Review Section) are completed, pointing out problems concerning utility of the issuance or of the published criteria for expeditious adjudication, and (2) a more general discussion of this issuance which should be sent to BDI at any time the need arises.

In both instances, send comments to the BDI Central Office, to the attention of Herbert L. Blumenfeld, M.D., Room 2300 Dickinson Building.

Bernard Popick, Director
Bureau of Disability Insurance

Attachments: Exhibits 1 and 2

January 9, 1974

Exhibit 1

Usefulness of "Adult" Listing of Impairments

(Appendix to Subpart P, Regulations No. 4) to Child Claims

- I. Childhood Impairment Guides
 - A. Discussion of these childhood impairments is being furnished at the present time:
 - Section C 100.00 – Growth.
 - Sections C 102.00G, C 102.08 – Hearing impairments.
 - Section C 107.05 – Sickle cell anemia.
 - Section C 107.11 – Acute leukemia.
 - Section C 109.08 – Juvenile diabetes mellitus.
 - Section C 110.08 – Multisystemic catastrophic disease.
 - Sections C 111.00A, C 111.02 – Convulsive seizures.
 - Section C 111.00C, C 111.07 – Cerebral palsy.
 - Section C 112.00 ff – Mental and emotional disorders.
 - Malignant neoplasms:
 - Section C 113.14 – Anterior Mediastinum.
 - Section C 113.19 – Liver.
 - Section C 113.24 – Testicles.
 - Section C 113.26 – Ovaries.
 - Section C 113.28 – Neuroblastoma.
 - Section C 113.29 – Wilms' tumor.
 - Section C 113.30 – Sacrococcygeal tumors.
 - Section C 113.31 – Teratocarcinoma or Choriocarcinoma.
 - Section C 113.32 – Retinoblastoma.

- B. These additional new guides will be furnished in the near future:

Cystic fibrosis.
Congenital heart disease.
Endocrine disorders.
Renal disorders.

- II. These published listings will be useful as written:

Sections 1.05A, 1.06, 1.09, 1.10, 1.11, 1.12.
Sections 2.02, 2.03A, 2.03B, 2.05, 2.06.
Sections 3.08B, 3.08C, 3.10.
Section 4.05.
Sections 5.04A, 5.04B, 5.04C, 5.05A, 5.05C,
5.05D, 5.06A, 5.06B, 5.06C, 5.07A,
5.07B.
Sections 6.02A, 6.04, 6.05.
Sections 7.07, 7.08, 7.10B, 7.13.
Section 8.00 ff.
Sections 9.08A, 9.08B1.
Section 10.00 ff.
Sections 11.04, 11.05, 11.08 to 11.14.
Section 13.00 ff, except 13.19, 13.24, 13.26.

- III. Disease seen in children, but level of severity or criteria description will need to be changed:

Sections 1.02, 1.04, 1.05C, 1.08
Sections 2.03C, 2.04, 2.08*.
Sections 3.07, 3.08A, 3.11.
Sections 4.02, 4.09, 4.10.
Sections 5.03, 5.04D, 5.05B, 5.06D, 5.07C, 5.08.
Sections 6.02B, 6.03.
Sections 7.02 to 7.04, 7.05*, 7.06, 7.09, 7.10A,
7.10C, 7.10D, 7.11*, 7.12, 7.14.
Sections 9.02 to 9.07, 9.08B2*.
Sections 11.02*, 11.03*, 11.07*, 11.17*.

Section 12.00 ff*.

Sections 13.19*, 13.24*, 13.26*.

(*Refer to new listing)

- IV. Generally not seen in young children:

Sections 1.03, 1.05B, 1.07.

Section 2.07.

Sections 3.02 to 3.06, 3.08D, 3.09.

Sections 4.03, 4.04, 4.06 to 4.08, 4.11 to 4.13.

Section 5.02.

Sections 9.08B3, 9.08B4.

Sections 11.06, 11.15, 11.16.

Exhibit 2

Childhood Impairment Guides

C 100.00 — *Growth Impairments*

C 100.00A — Determinations of growth impairment should be based on the comparison of current height with at least three previous determinations, including length at birth, if available. Heights (or lengths) should be plotted on the Standard Growth Chart prepared by the Harvard School of Public Health; this should be included in the folder. Height should be measured without shoes. Body weight corresponding to the ages represented by the heights should be furnished, if available. The adult heights of the child's natural parents and the height and age of siblings should also be furnished, if available, to provide a basis upon which to identify those children whose short stature represents a family characteristic rather than a result of disease.

Bone age determinations should include a full descriptive report, and must cite the standardization method used. Where roentgenograms have not previously been obtained to determine bone age in a child otherwise displaying apparent growth retardation, they must be obtained currently as a basis for adjudication under the following criteria. Where bone roentgenograms are obtained by the Administration, views of the left hand and wrist should be ordered. Additional roentgenograms of the knee and ankle should

be obtained when cessation of growth is being evaluated. The result of such roentgenograms should always be made available to the treating physician. The requirement of bone age retardation is not applicable to individuals with growth impairment resulting from malabsorption; growth impairment in these individuals should be considered under the criteria in Section C 100.02B and C. The criteria in this section are applicable only until closure of the major epiphyses.

C 100.01 — *Category of Impairments, Growth*

C 100.02 Growth impairment, as evidenced by bone age greater than one standard deviation (1 SD) below the mean for chronological age, and one of the following:

- A. Continuing or sustained fall of greater than 25 percentiles in height; or
- B. Continuing or sustained fall of greater than 15 percentiles in height *and* an additional medically determined impairment; or
- C. Fall to, or persistence of, height below the third percentile *and* an additional medically determined impairment.

C 102.00 — *Special Sense Organs*

C 102.00D *Deafness.* The criteria for hearing loss in children take into account that a smaller loss occurring at an early age, which is not correctable by definitive short-term therapy, may result in a severe speech defect. The criteria in Section 102.08 describe conditions most applicable in the younger age group,

and should be used in children through 12 years of age. Above the age of 12 years, the criteria in Section 2.08 should be applied.

Improvement by a hearing aid, as predicted by the testing procedure, must be demonstrated to be feasible in that child, since younger children may be unable to use a hearing aid effectively.

The type of testing performed should be described. A copy of the graphic representation of audiometric testing should be included in the report. If a standard audiometer is used, as will usually be the case, the report should indicate whether the apparatus was calibrated according to American National Standard Institute Specifications for Audiometers, S 3.6-1969 (ANSI-1969) or American Standard, Z 24.5-1951 (ASA-1951). The decibel levels cited in Section C 102.08 are based on use of the ANSI-1969 calibration. Testing should be done at the three frequencies of 500, 1000 and 2000 Hertz (Hz). Auditory perception of better than the level required in Section 102.08 at only a single tonal frequency between 500 and 2000 Hz will be considered as meeting the requirements of the criteria.

C 102.08 *Hearing Impairments*

- A. For children whose claims are adjudicated below age 5 years, absence of bilateral auditory perception at greater than 40 decibels; or

- B. For children whose claims are adjudicated from 5 years of age and above:

1. Absence of bilateral auditory perception at greater than 80 decibels, not correctable by a hearing aid; or
2. Absence of bilateral auditory perception at greater than 40 decibels, not correctable by a hearing aid *and* speech deficit involving clarity and content, attributable to the hearing loss.

C 107.00 *Hemic and Lymphatic System*

C 107.00B - *Leukemia*: The criteria in Section C 107.11 take into account the implications and consequences to the child attendant upon this diagnosis, as well as the recent great strides in treatment, which an increasing number of prolonged, sustained remissions.

C 107.05 - *Sickle Cell Anemia*: With hematocrit of 25 percent or less; and

- A. Growth retardation as in Section C 100.00; or
- B. Documented recurrent, severe, painful (thrombotic) crises; or
- C. Recurrent major lower respiratory infections requiring hospitalization; or
- D. A major complication (such as hyperhemolytic or aplastic crisis, renal or cardiac failure, severe meningitis, or osteomyelitis) within six months preceding adjudication.

C 107.11 — *Acute Leukemia:*

- A. Consider under severe impairment for one year after complete remission; or
- B. With relapse or recurrence.

C 109.08 *Juvenile Diabetes Mellitus*

- A. *Juvenile diabetes mellitus* manifested by significant ketonemia or lowering of plasma bicarbonate or pH requiring hospital care on the average of at least once every two months.
- B. *Juvenile diabetes mellitus* with growth retardation (such as in Moriak syndrome or with malabsorption or renal disease).
- C. When juvenile diabetes mellitus exists or results in other physical or mental impairments, consider in conjunction with the criteria for the appropriate body system.

C 110.00 *Multiple Body System*C 110.08 *Catastrophic Congenital Abnormalities or Disease*

- A. With a positive diagnosis (such as anencephaly, trisomy D or E, cyclopsia, etc.), generally regarded as being incompatible with extra-uterine life; or
- B. With a positive diagnosis (such as cri du chat, Tay-Sachs, maple syrup urine disease, etc.), wherein attainment of the growth and development level of two years is not expected to occur.

C 111.00 *Neurological*

C 111.00A *Convulsive Seizures:* The documentation of epilepsy in childhood is subject to the same requirement stated in Section 11.00A. Criteria have been provided in Section C 111.02 for infantile myoclonic seizures and for major convulsive seizures in combination with other impairments. Specific criteria for adjudication of cases involving only major convulsive seizures in children are not being furnished at the present time. Seizures in children may differ from those in adults in terms of pattern, duration, and manifestations of the post-ictal phase and response to therapy. The impact on the child's life may be different. The criteria in Section 11.02 or 11.03 are not felt to describe impairments which significantly interfere with growth or development in a child or which constitute an "impairment of comparable severity" as required in Section 1614(a)(3)(A) of Public Law 92-603. Adjudication of childhood claims based on major convulsive seizures, unaccompanied by another significant impairment should take into account the impact on the child of seizure episodes, duration of the post-ictal phase, and other residua, and the extent to which these interfere with major daily activities for age or progression of development.

C 111.00C *Cerebral Palsy:* Documentation of cerebral palsy should include results of an examination describing the area of neuromuscular involvement, the appearance, any contractures or deformities, and the degree of spasticity, weakness, tremor, ataxia, or athetosis.

The requirement of significant interference with the stated functions in Section C 111.07A should be interpreted as requiring a level of involvement on a neuro-musculo-skeletal basis alone which will interfere with the child's major daily activities for age and with progression of development. The criteria in Sections C 111.07C through F are based on the combined effect of two or more impairments, each of which is short of the requirements listed for a single impairment, but is greater than of slight or mild severity.

- C 111.02 *Major Convulsive Seizures:* Occurring in spite of prescribed therapy.
- A. See Section C 111.00A; or
 - B. In combination with:
 1. I.Q. below 70; or
 2. Cerebral palsy; or
 3. Emotional disorder; or
 4. Impaired vision, hearing, or speech; or
 - C. Infantile myoclonic seizures with characteristic EEG pattern of hypsarrhythmia.
- C 111.07 *Cerebral Palsy:* With persistent spasticity, weakness, tremor, ataxia, or athetosis involving two extremities; and
- A. Significant interference with gross and fine movements or locomotion and station for age; or
 - B. Positive diagnosis of cerebral palsy made before one year of age; or
 - C. I.Q. below 70; or
 - D. Convulsive seizures; or

- E. Impaired vision, hearing, or speech; or
- F. Mental or emotional disorder.

C 112.00

Mental and Emotional Disorders

This section is primarily intended to describe mental and emotional disorders of young children. The medical criteria describing impairments in adults should be used when they clearly appear to be more appropriate.

Mental retardation (C 112.05) should be determined on the basis of medical reports, I.Q. measurements, and developmental milestone criteria. Standardized tests such as the Wechsler Preschool and Primary Scale of Intelligence (WPPSI), the Wechsler Intelligence Scale for Children (WISC), the Binet, and the Bayley Scale should be used whenever possible. Key data such as subtest scores should be included in the report.

Developmental milestone criteria (such as appear in standard pediatric texts and the February 1973 *Pediatric Clinics of North America*) should be included. When the age and condition of the child preclude the standardized tests described above, developmental criteria, based upon a physician's evaluation, may be the basis for adjudication.

Other widely used pediatric screening devices (such as the Denver Developmental, the "Draw-A-Person", and the Peabody Picture Vocabulary Test) should be included whenever this information is available.

C 112.02

Chronic Brain Syndrome with arrest of developmental progression for six months or loss of previously acquired abilities.

- C 112.03 *Psychosis of Infancy and Childhood* manifested by impaired relationships with others, impaired sense of reality, and one of the following:
- A. Significant withdrawal or detachment, or
 - B. Bizarre behavior patterns, or
 - C. Strong need for maintenance of sameness, with intense anxiety, fear, and anger when change is introduced, or
 - D. Panic at threat of separation from parent.
- C 112.04 *Functional Non-Psychotic Disorders* with symptom formation which renders the child unable to perform major daily age-appropriate activities, and one of the following:
- A. Psychophysiologic disorder.
 - B. Marked anxiety.
 - C. Weight loss with malnutrition (see Section C 100.00 ff).
 - D. Persistent inappropriate behavior (i.e., excessive pre-occupation, withdrawal, or compulsive-ritualistic behavior).
- C 112.05 *Mental Retardation*
- A. Achievement of only those developmental milestones generally acquired by children up to one-half the child's chronologic age, or
 - B. I.Q. of 59 or less, or
 - C. I.Q. of 60-69, inclusive, with marked dependence, for age, upon others for basic personal needs (i.e., feeding,

washing) and a physical or other mental impairment resulting in restriction of function and developmental progression.

- C 113.00 *Neoplastic Diseases—Malignant*
- C 113.14 *Anterior Mediastinum*
- A. Teratoma with recurrence; or
 - B. Malignant thymoma with recurrence; or
 - C. Ganglioneuroma with malignant change or recurrence.
- C 113.19 *Liver*
- A. Hepatoblastoma, argentaffinoma, or hepatic or biliary cell carcinoma; or
 - B. Metastatic malignant tumors to liver.
- C 113.24 *Testicles*
- A. Teratocarcinoma, choriocarcinoma, or embryonal cell carcinoma; or
 - B. Seminoma not controlled by prescribed therapy.
- C 113.26 *Ovaries*
- A. Teratocarcinoma, choriocarcinoma, or adenocarcinoma; or
 - B. Granulosa or thecal cell tumors, or arrhenoblastoma, with
 - 1. Metastases; or
 - 2. Recurrence.
- C 113.28 *Neuroblastoma*
- A. Onset at 24 months of age or later; or
 - B. Bone or marrow involvement; or
 - C. Not controlled by definitive therapy; or
 - D. Recurrent after definitive therapy.

- C 113.29 *Wilms' Tumors*
 A. Not controlled by prescribed therapy; or
 B. Recurrent.
- C 113.30 *Sacroccygeal Tumors*
 A. Malignant, or
 B. Histologically benign tumors recurrent after radical surgery.
- C 113.31 *Teratocarcinoma or Choriocarcinoma*: Occurring in any location except anterior mediastinum (See Section C 113.14A).
- C 113.32 *Retinoblastoma*
 A. Bilateral involvement; or
 B. Metastatic or extending beyond the orbit; or
 C. Recurrent.

LISTING OF IMPAIRMENTS
20 C.F.R. Part 404, Subpart P, Appendix 1 (1988)

In the Listing of Impairments, the listings under each separate body system in both Part A and Part B will be effective for periods ranging from 4 to 8 years unless extended or revised and promulgated again. Specifically, the body system listings in the Listing of Impairments will be subject to the following termination dates:

Musculoskeletal system (1.00) within 5 years. Consequently, the listings in this body system will no longer be effective on December 6, 1990.

Respiratory system (3.00) within 6 years. Consequently, the listings in this body system will no longer be effective on December 6, 1991.

Cardiovascular system (4.00) within 4 years. Consequently, the listings in this body system will no longer be effective on December 6, 1989.

The listings under the other body systems in Part A and Part B will expire in 8 years. Consequently, the listing in these body systems will no longer be effective on December 6, 1993. The mental disorders listings in Part A will expire on August 27, 1988, unless extended or revised and promulgated again.

Part A

Criteria applicable to individuals age 18 and over and to children under age 18 where criteria are appropriate.

Sec.

- 1.00 Musculoskeletal System.
- 2.00 Special Senses and Speech.
- 3.00 Respiratory System.
- 4.00 Cardiovascular System.
- 5.00 Digestive System.
- 6.00 Genito-Urinary System.

- 7.00 Hemic and Lymphatic System.
- 8.00 Skin.
- 9.00 Endocrine System.
- 10.00 Multiple Body Systems.
- 11.00 Neurological.
- 12.00 Mental Disorders.
- 13.00 Neoplastic Diseases, Malignant.

1.00 MUSCULOSKELETAL SYSTEM

A. *Loss of function* may be due to amputation or deformity. Pain may be an important factor in causing functional loss, but it must be associated with relevant abnormal signs or laboratory findings. Evaluations of musculoskeletal impairments should be supported where applicable by detailed descriptions of the joints, including ranges of motion, condition of the musculature, sensory or reflex changes, circulatory deficits, and X-ray abnormalities.

B. *Disorders of the spine*, associated with verte-brogenic disorders as in 1.05C, result in impairment because of distortion of the bony and ligamentous architecture of the spine or impingement of a herniated nucleus pulposus or bulging annulus on a nerve root. Impairment caused by such abnormalities usually improves with time or responds to treatment. Appropriate abnormal physical findings must be shown to persist on repeated examinations despite therapy for a reasonable presumption to be made that severe impairment will last for a continuous period of 12 months. This may occur in cases with unsuccessful prior surgical treatment.

Evaluation of the impairment caused by disorders of the spine requires that a clinical diagnosis of the entity to be evaluated first must be established on the basis of adequate history, physical examination, and roentgenograms.

The specific findings stated in 1.05C represent the level required for that impairment; these findings, by themselves, are not intended to represent the basis for establishing the clinical diagnosis. Furthermore, while neurological examination findings are required, they are not to be interpreted as a basis for evaluating the magnitude of any neurological impairment. Neurological impairments are to be evaluated under 11.00-11.19.

The history must include a detailed description of the character, location, and radiation of pain; mechanical factors which incite and relieve pain; prescribed treatment, including type, dose, and frequency of analgesic; and typical daily activities. Care must be taken to ascertain that the reported examination findings are consistent with the individual's daily activities.

There must be a detailed description of the orthopedic and neurologic examination findings. The findings should include a description of gait, limitation of movement of the spine given quantitatively in degrees from the vertical position, motor and sensory abnormalities, muscle spasm, and deep tendon reflexes. Observations of the individual during the examination should be reported; e.g., how he or she gets on and off the examining table. Inability to walk on heels or toes, to squat, or to arise from a squatting position, where appropriate, may be considered evidence of significant motor loss. However, a report of atrophy is not acceptable as evidence of significant motor loss without circumferential measurements of both thighs and lower legs (or upper or lower arms) at a stated point above and below the knee or elbow given in inches or centimeters. A specific description of atrophy of hand muscles is acceptable without measurements of atrophy but should include measurements of grip strength.

These physical examination findings must be determined on the basis of objective observations during the

examination and not simply a report of the individual's allegation, e.g., he says his leg is weak, numb, etc. Alternative testing methods should be used to verify the objectivity of the abnormal findings, e.g., a seated straight-leg raising test in addition to a supine straight-leg raising test. Since abnormal findings may be intermittent, their continuous presence over a period of time must be established by a record of ongoing treatment. Neurological abnormalities may not completely subside after surgical or nonsurgical treatment, or with the passage of time. Residual neurological abnormalities, which persist after it has been determined clinically or by direct surgical or other observation that the ongoing or progressive condition is no longer present, cannot be considered to satisfy the required findings in 1.05C.

Where surgical procedures have been performed, documentation should include a copy of the operative note and available pathology reports.

Electrodiagnostic procedures and myelography may be useful in establishing the clinical diagnosis, but do not constitute alternative criteria to the requirements in 1.05C.

C. *After maximum benefit from surgical therapy* has been achieved in situations involving fractures of an upper extremity (see 1.12) or soft tissue injuries of a lower or upper extremity (see 1.13), i.e., there have been no significant changes in physical findings or X-ray findings for any 6-month period after the last definitive surgical procedure, evaluation should be made on the basis of demonstrable residuals.

D. *Major joints* as used herein refer to hip, knee, ankle, shoulder, elbow, or wrist and hand. (Wrist and hand are considered together as one major joint.)

E. *The measurements of joint motion* are based on the techniques described in the "Joint Motion Method of Measuring and Recording," published by the American Academy of Orthopedic Surgeons in 1965, or the "Guides

to the Evaluation of Permanent Impairment—The Extremities and Back" (Chapter I); American Medical Association, 1971.

1.01 Category of Impairments, Musculoskeletal

1.02 *Active rheumatoid arthritis and other inflammatory arthritis.*

With both A and B.

A. History of persistent joint pain, swelling, and tenderness involving multiple major joints (see 1.00D) and with signs of joint inflammation (swelling and tenderness) on current physical examination despite prescribed therapy for at least 3 months, resulting in significant restriction of function of the affected joints, and clinical activity expected to last at least 12 months; and

B. Corroboration of diagnosis at some point in time by either.

1. Positive serologic test for rheumatoid factor; or
2. Antinuclear antibodies; or
3. Elevated sedimentation rate; or
4. Characteristic histologic changes in biopsy of synovia membrane or subcutaneous nodule (obtained independent of Social Security disability evaluation).

1.03 *Arthritis of a major weight-bearing joint (due to any cause):*

With history of persistent joint pain and stiffness with signs of marked limitation of motion or abnormal motion of the affected joint on current physical examination. With:

A. Gross anatomical deformity of hip or knee (e.g., subluxation, contracture, bony or fibrous ankylosis, instability) supported by X-ray evidence of either significant joint space narrowing or significant bony destruction and markedly limiting ability to walk and stand; or

B. Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint and return to full weight-bearing.

ing status did not occur, or is not expected to occur, within 12 months of onset.

1.04 Arthritis of one major joint in each of the upper extremities (due to any cause):

With history of persistent joint pain and stiffness, signs of marked limitation of motion of the affected joints on current physical examination, and X-ray evidence of either significant joint space narrowing or significant bony destruction. With:

A. Abduction and forward flexion (elevation) of both arms at the shoulders, including scapular motion, restricted to less than 90 degrees; or

B. Gross anatomical deformity (e.g., subluxation, contracture, bony or fibrous ankylosis, instability, ulnar deviation) and enlargement or effusion of the affected joints.

1.05 Disorders of the spine:

A. Arthritis manifested by ankylosis or fixation of the cervical or dorsolumbar spine at 30° or more of flexion measured from the neutral position, with X-ray evidence of:

1. Calcification of the anterior and lateral ligaments; or

2. Bilateral ankylosis of the sacroiliac joints with abnormal apophyseal articulations; or

B. Osteoporosis, generalized (established by X-ray) manifested by pain and limitation of back motion and paravertebral muscle spasm with X-ray evidence of either:

1. Compression fracture of a vertebral body with loss of at least 50 percent of the estimated height of the vertebral body prior to the compression fracture, with no intervening direct traumatic episode; or

2. Multiple fractures of vertebrae with no intervening direct traumatic episode; or

C. Other vertebrogenic disorders (e.g., herniated nucleus pulposus, spinal stenosis) with the following persisting for at least 3 months despite prescribed therapy and expected to last 12 months. With both 1 and 2:

1. Pain, muscle spasm, and significant limitation of motion in the spine; and

2. Appropriate radicular distribution of significant motor loss with muscle weakness and sensory and reflex loss.

1.08 Osteomyelitis or septic arthritis (established by X-ray):

A. Located in the pelvis, vertebra, femur, tibia, or a major joint of an upper or lower extremity, with persistent activity or occurrence of at least two episodes of acute activity within a 5-month period prior to adjudication, manifested by local inflammatory, and systemic signs and laboratory findings (e.g., heat, redness, swelling, leucocytosis, or increased sedimentation rate) and expected to last at least 12 months despite prescribed therapy; or

B. Multiple localizations and systemic manifestations as in A above.

1.09 Amputation or anatomical deformity of (i.e., loss of major function due to degenerative changes associated with vascular or neurological deficits, traumatic loss of muscle mass or tendons and X-ray evidence of bony ankylosis at an unfavorable angle, joint subluxation or instability):

A. Both hands; or

B. Both feet; or

C. One hand and one foot.

1.10 Amputation of one lower extremity (at or above the tarsal region):

A. Hemipelvectomy or hip disarticulation; or

B. Amputation at or above the tarsal region due to peripheral vascular disease or diabetes mellitus; or

C. Inability to use a prosthesis effectively, without obligatory assistive devices, due to one of the following:

1. Vascular disease; or
2. Neurological complications (e.g., loss of position sense); or
3. Stump too short or stump complications persistent, or are expected to persist, for at least 12 months from onset; or
4. Disorder of contralateral lower extremity which markedly limits ability to walk and stand.

1.11 *Fracture of the femur, tibia, tarsal bone of pelvis* with solid union not evident on X-ray and not clinically solid, when such determination is feasible, and return to full weight-bearing status did not occur or is not expected to occur within 12 months of onset.

1.12 *Fractures of an upper extremity* with non-union of a fracture of the shaft of the humerus, radius, or ulna under continuing surgical management directed toward restoration of functional use of the extremity and such function was not restored or expected to be restored within 12 months after onset.

1.13 *Soft tissue injuries of an upper or lower extremity* requiring a series of staged surgical procedures within 12 months after onset for salvage and/or restoration of major function of the extremity, and such major function was not restored or expected to be restored within 12 months after onset.

2.00 SPECIAL SENSES AND SPEECH

A. Ophthalmology

1. *Causes of impairment.* Diseases or injury of the eyes may produce loss of central or peripheral vision. Loss of central vision results in inability to distinguish detail and prevents reading and fine work. Loss of peripheral

vision restricts the ability of an individual to move about freely. The extent of impairment of sight should be determined by visual testing.

2. *Central visual acuity.* A loss of central visual acuity may be caused by impaired distant and/or near vision. However, for an individual to meet the level of severity described in 2.02 and 2.04, only the remaining central visual acuity for distance of the better eye with best correction based on the Snellen test chart measurement may be used. Correction obtained by special visual aids (e.g., contact lenses) will be considered if the individual has the ability to wear such aids.

3. *Field of vision.* Impairment of peripheral vision may result if there is contraction of the visual fields. The contraction may be either symmetrical or irregular. The extent of the remaining peripheral visual field will be determined by usual perimetric methods at a distance of 330 mm. under illumination of not less than 7-foot candles. For the phakic eye (the eye with a lense), a 3 mm. white disc target will be used, and for the aphakic eye (the eye without the lens), a 6 mm. white disc target will be used. In neither instance should corrective spectacle lenses be worn during the examination but if they have been used, this fact must be stated.

Measurements obtained on comparable perimetric devices may be used; this does not include the use of tangent screen measurements. For measurements obtained using the Goldmann perimeter, the object size designation III and the illumination designation 4 should be used for the phakic eye, and the object size designation IV and illumination designation 4 for the aphakic eye.

Field measurements must be accompanied by notated field charges, a description of the type and size of the target and the test distance. Tangent screen visual fields are not acceptable as a measurement of peripheral field loss.

Where the loss is predominantly in the lower visual fields, a system such as the weighted grid scale for perimetric fields described by B. Esterman (see Grid for Scoring Visual Fields, II. Perimeter, *Archives of Ophthalmology*, 79:400, 1968) may be used for determining whether the visual field loss is comparable to that described in Table 2.

4. *Muscle function.* Paralysis of the third cranial nerve producing ptosis, paralysis of accommodation, and dilation and immobility of the pupil may cause significant visual impairment. When all the muscle of the eye are paralyzed including the iris and ciliary body (total ophthalmoplegia), the condition is considered a severe impairment provided it is bilateral. A finding of severe impairment based primarily on impaired muscle function must be supported by a report of an actual measurement of ocular motility.

5. *Visual efficiency.* Loss of visual efficiency may be caused by disease or injury resulting in a reduction of central visual acuity or visual field. The visual efficiency of one eye is the product of the percentage of central visual efficiency and the percentage of visual field efficiency. (See Tables No. 1 and 2, following 2.09.)

6. *Special situations.* Aphakia represents a visual handicap in addition to the loss of central visual acuity. The term monocular aphakia would apply to an individual who has had the lens removed from one eye, and who still retains the lens in his other eye, or to an individual who has only one eye which is aphakic. The term binocular aphakia would apply to an individual who has had both lenses removed. In cases of binocular aphakia, the central efficiency of the better eye will be accepted as 75 percent of its value. In cases of monocular aphakia, where the better eye is aphakic, the central visual efficiency will be accepted as 50 percent of the value. (If an individual has

binocular aphakia, and the central visual acuity in the poorer eye can be corrected only to 20/200, or less, the central visual efficiency of the better eye will be accepted as 50 percent of its value.)

Ocular symptoms of systemic disease may or may not produce a disabling visual impairment. These manifestations should be evaluated as part of the underlying disease entity by reference to the particular body system involved.

7. *Statutory blindness.* The term "statutory blindness" refers to the degree of visual impairment which defines the term "blindness" in the Social Security Act. Both 2.02 and 2.03 A and B denote statutory blindness.

B. *Otolaryngology*

1. *Hearing impairment.* Hearing ability should be evaluated in terms of the person's ability to hear and distinguish speech.

Loss of hearing can be quantitatively determined by an audiometer which meets the standards of the American National Standards Institute (ANSI) for air and bone conducted stimuli (i.e., ANSI S 3.6-1969 and ANSI S 3.13-1972, or subsequent comparable revisions) and performing all hearing measurements in an environment which meets the ANSI standard for maximal permissible background sound (ANSI S 3.1-1977).

Speech discrimination should be determined using a standardized measure of speech discrimination ability in quiet at a test presentation level sufficient to ascertain maximum discrimination ability. The speech discrimination measure (test) used, and the level at which testing was done, must be reported.

Hearing tests should be preceded by an otolaryngologic examination and should be performed by or under the supervision of an otolaryngologist or audiologist qualified to perform such tests.

In order to establish an independent medical judgment as to the level of impairment in a claimant alleging deafness, the following examinations should be reported: Otolaryngologic examination, pure tone air and bone audiometry, speech reception threshold (SRT), and speech discrimination testing. A copy of reports of medical examination and audiologic evaluations must be submitted.

Cases of alleged "deaf mutism" should be documented by a hearing evaluation. Records obtained from a speech and hearing rehabilitation center or a special school for the deaf may be acceptable, but if these reports are not available, or are found to be inadequate, a current hearing evaluation should be submitted as outlined in the preceding paragraph.

2. *Vertigo associated with disturbances of labyrinthine-vestibular function, including Meniere's disease.* These disturbances of balance are characterized by an hallucination of motion or loss of position sense and a sensation of dizziness which may be constant or may occur in paroxysmal attacks. Nausea, vomiting, ataxia, and incapacitation are frequently observed, particularly during the acute attack. It is important to differentiate the report of rotary vertigo from that of "dizziness" which is described as light-headedness, unsteadiness, confusion, or syncope.

Meniere's disease is characterized by paroxysmal attacks of vertigo, tinnitus, and fluctuating hearing loss. Remissions are unpredictable and irregular, but may be long-lasting; hence, the severity of impairment is best determined after prolonged observation and serial reexaminations.

The diagnosis of a vestibular disorder requires a comprehensive neuro-otolaryngologic examination with a detailed description of the vertiginous episodes, including notation of frequency, severity, and duration of the attacks. Pure tone and speech audiometry with the appro-

priate special examinations, such as Bekesy audiometry, are necessary. Vestibular functions is assessed by positional and caloric testing, preferably by electronystagmography. When polytograms, contrast radiography, or other special tests have been performed, copies of the reports of these tests should be obtained in addition to reports of skull and temporal bone X-rays.

3. *Organic loss of speech.* Glossectomy or laryngectomy or cicatricial laryngeal stenosis due to injury or infection results in loss of voice production by normal means. In evaluating organic loss of speech (see 2.09), ability to produce speech by any means includes the use of mechanical or electronic devices. Impairment of speech due to neurologic disorders should be evaluated under 11.00-11.19.

2.01 Category of Impairments, Special Senses and Speech

2.02 *Impairment of central visual acuity.* Remaining vision in the better eye after best correction is 20/200 or less.

2.03 *Contraction of peripheral visual fields in the better eye.*

A. To 10° or less from the point of fixation; or

B. So the widest diameter subtends an angle no greater than 20°; or

C. To 20 percent or less visual field efficiency.

2.04 *Loss of visual efficiency.* Visual efficiency of better eye after best correction 20 percent or less. (The percent of remaining visual efficiency = the product of the percent of remaining central visual efficiency and the percent of remaining visual field efficiency.)

2.05 *Complete homonymous hemianopsia* (with or without macular sparing). Evaluate under 2.04.

2.06 *Total bilateral ophthalmoplegia.*

2.07 *Disturbance of labyrinthine-vestibular function (including Meniere's disease)*, characterized by a history of frequent attacks of balance disturbance, tinnitus, and progressive loss of hearing. With both A and B:

A. Disturbed function of vestibular labyrinth demonstrated by caloric or other vestibular tests; and

B. Hearing loss established by audiometry.

2.08 *Hearing impairments* (hearing not restorable by a hearing aid) manifested by:

A. Average hearing threshold sensitivity for air conduction of 90 decibels or greater and for bone conduction to corresponding maximum levels, in the better ear, determined by the simple average of hearing threshold levels at 500, 1000 and 2000 hz. (see 2.00B1); or

B. Speech discrimination scores of 40 percent or less in the better ear;

2.09 *Organic loss of speech* due to any cause with inability to produce by any means speech which can be heard understood and sustained.

Table No. 1 — Percentage of Central Visual Efficiency Corresponding to Central Visual Acuity Notations for Distance in the Phakic and Aphakic Eye (Better Eye)

Snellen		Percent central visual efficiency		
English	Metric	Phakic ¹	Aphakic monocular ²	Aphakic binocular ³
20/16	6/5	100	50	75
20/20	6/6	100	50	75
20/25	6/7.5	95	47	71
20/32	6/10	90	45	67
20/40	6/12	85	42	64
20/50	6/15	75	37	56
20/64	6/20	65	32	49
20/80	6/24	60	30	45
20/100	6/30	50	25	37
20/125	6/38	40	20	30
20/160	6/48	30	22
20/200	6/60	20

Column and Use.

¹ Phakic. — 1. A lense is present in both eyes. 2. A lense is present in the better eye and absent in the poorer eye. 3. A lense is present in one eye and the other eye is enucleated.

² Monocular. — 1. A lense is absent in the better eye and present in the poorer eye. 2. The lenses are absent in both eyes; however, the central visual acuity in the poorer eye after best correction is 20/200 or less. 3. A lense is absent from one eye and the other eye is enucleated.

³ Binocular. — 1. The lenses are absent from both eyes and the central visual acuity in the poorer eye after best correction is greater than 20/200.

[CHART OMITTED]

Table No. 2—Chart of Visual Field Showing Extent of Normal Field and Method of Computing Percent of Visual Field Efficiency

1. Diagram of right eye illustrates extent of normal visual field as tested on standard perimeter at 3/330 (3 mm. white disc at a distance of 330 mm.) under 7 foot-candles illumination. The sum of the eight principal meridians of this field total 500°.

2. The percent of visual field efficiency is obtained by adding the number of degrees of the eight principal meridians of the contracted field and dividing by 500. Diagram of left eye illustrates visual field contracted to 30° in the temporal and down and out meridians and to 20° in the remaining six meridians. The percent of visual field efficiency of this field is: $6 \times 20 + 2 \times 30 = 180 \div 500 = 0.36$ or 36 percent remaining visual field efficiency, or 64 percent loss.

3.00 RESPIRATORY SYSTEM

A. *Introduction:* Impairments caused by the chronic disorder of the respiratory system generally result from irreversible loss of pulmonary functional capacity (ventilatory impairment, gas exchange impairment, or a combination of both). The most common symptom attributable to these disorders is dyspnea on exertion. Cough, wheezing, sputum production, hemoptysis, and chest pain may also occur, but need not be present. However, since these symptoms are common to many other diseases, evaluation of impairments of the respiratory system requires a history, physical examination, and chest roentgenogram to establish the diagnosis of a chronic respiratory disorder. Pulmonary function testing is required to provide a basis for

assessing the impairment, once the diagnosis is established by appropriate clinical findings.

Alteration of ventilatory function may be due primarily to chronic obstructive pulmonary disease (emphysema, chronic bronchitis, chronic asthmatic bronchitis) or restrictive disorders with primary loss of lung volume (pulmonary resection, thoracoplasty, chest cage deformity as seen in kyphoscoliosis), or infiltrative interstitial disorders (diffuse fibrosis). Impairment of gas exchange without significant airway obstruction may be produced by interstitial disorders (diffuse fibrosis). Primary disease of pulmonary circulation may produce pulmonary vascular hypertension and, eventually, heart failure. Whatever the mechanism, any chronic progressive pulmonary disorder may result in cor pulmonale or heart failure. Chronic infection caused, most frequently by mycobacterial or mycotic organisms, may produce extensive lung destruction resulting in marked loss of pulmonary functional capacity. Some disorders such as bronchiectasis and asthma may be characterized by acute, intermittent illnesses of such frequency and intensity that they produce a marked impairment apart from intercurrent functional loss, which may be mild.

Most chronic pulmonary disorders may be adequately evaluated on the basis of history, physical examination, chest roentgenogram, and ventilatory function tests. Direct assessment of gas exchange by exercise arterial blood gas determination or diffusing capacity is required only in specific relatively rare circumstances, depending on the clinical features and specific diagnosis.

B. *Mycobacterial and mycotic infections of the lung* will be evaluated on the basis of the resulting impairment to pulmonary function. Evidence of infectious or active mycobacterial or mycotic infection, such as positive cultures, increasing lesions, or cavitation, is not, by itself,

a basis for determining that the individual has a severe impairment which is expected to last 12 months. However, if these factors are abnormally persistent, they should not be ignored. For example, in those unusual cases where there is evidence of persistent pulmonary infection caused by mycobacterial or mycotic organisms for a period closely approaching 12 consecutive months, the clinical findings, complications, treatment considerations, and prognosis must be carefully assessed to determine whether, despite the absence of impairment of pulmonary function, the individual has a severe impairment that can be expected to last for 12 consecutive months.

C. *When a respiratory is episodic in nature*, as may occur in complications of bronchiectasis and asthmatic bronchitis, the frequency of severe episodes despite prescribed treatment is the criterion for determining the level of impairment. Documentation for episodic asthma should include the hospital or emergency room records indicating the dates of treatment, clinical findings on presentation, what treatment was given and for what period of time, and the clinical response. Severe attacks of episodic asthma, as listed in section 3.03B, are defined as prolonged episodes lasting at least several hours, requiring intensive treatment such as intravenous drug administration or inhalation therapy in a hospital or emergency room.

D. *Documentation of ventilatory function tests.* The results of ventilatory function studies for evaluation under tables I and II should be expressed in liters or liters per minute (BTPS). The reported one second forced expiratory volume (FEV₁) should represent the largest of at least three attempts. One satisfactory maximum voluntary ventilation (MVV) is sufficient. The MVV should represent the observed value and should not be calculated from FEV₁. These studies should be repeated after administration of a nebulized bronchodilator unless the prebroncho-

dilator values are 80 percent or more of predicted normal values or the use of bronchodilators is contraindicated. The values in tables I and II assume that the ventilatory function studies were not performed in the presence of wheezing or other evidence of bronchospasm or, if these were present at the time of the examination, that the studies were repeated after administration of a bronchodilator. Ventilatory function studies performed in the presence of bronchospasm, without use of bronchodilators, cannot be found to meet the requisite level of severity in tables I and II.

The appropriately labeled spirometric tracing, showing distance per second on the abscissa and the distance per liter on the ordinate, must be incorporated in the file. The manufacturer and model number of the device used to measure and record the ventilatory function should be stated. If the spirogram was generated other than by direct pen linkage to a mechanical displacement-type spirometer, the spirometric tracing must show the calibration of volume units through mechanical means such as would be obtained using a giant syringe. The FEV₁ must be recorded at a speed of at least 20 mm. per second. Calculation of the FEV₁ from a flow volume loop is not acceptable. The recording device must provide a volume excursions of at least 10 mm. per liter. The MVV should be represented by the tidal excursions measured over a 10- to 15-second interval. Tracings showing only cumulative volume for the MVV are not acceptable. The ventilatory function tables are based on measurement of the height of the individual without shoes. Studies should not be performed during or soon after an acute respiratory illness. A statement should be made as to the individual's ability to understand the directions and cooperate in performing the test.

E. *Documentation of chronic impairment of gas exchange—Arterial blood gases and exercise tests.*

1. *Introduction:* Exercise tests with measurement of arterial blood gases at rest and during exercise should be purchased when not available as evidence of record in cases in which there is documentation of chronic pulmonary disease, but the existing evidence, including properly performed ventilatory function tests, is not adequate to evaluate the level of the impairment. Before purchasing arterial blood gas tests, medical history, physical examination, report of chest roentgenogram, ventilatory function tests, electrocardiographic tracing, and hematocrit must be obtained and should be evaluated by a physician competent in pulmonary medicine. Arterial blood gas tests should not be purchased where full development short of such purchase reveals that the impairment meets or equals any other listing or when the claim can be adjudicated on some other basis. Capillary blood analysis for PO_2 or PCO_2 is not acceptable. Analysis of arterial blood gases obtained after exercise is stopped is not acceptable.

Generally individuals with an FEV_1 greater than 2.5 liters or an MVV greater than 100 liters per minute would not be considered for blood gas studies unless diffuse interstitial pulmonary fibrosis was noted on chest X-ray or documented by tissue diagnosis. The exercise test facility should be provided with the clinical reports, report of chest roentgenogram, and spirometry results obtained by the DDS. The testing facility should determine whether exercise testing is clinically contraindicated. If an exercise test is clinically contraindicated, the reason for exclusion from the test should be stated in the report of the exercise test facility.

2. *Methodology.* Individuals considered for exercise testing first should have resting PaO_2 , $PaCO_2$, and pH determinations by the testing facility. The samples should

be obtained in the sitting or standing position. The individual should be exercised under steady state conditions, preferably on a treadmill for a period of 6 minutes at a speed and grade providing a workload of approximately 17 ml. O_2 /kg./min. If a bicycle ergometer is used, an exercise equivalent of 450 kgm./min., or 75 watts, should be used. At the option of the facility, a warm-up period of treadmill walking may be performed to acquaint the applicant with the procedure. If, during the warm-up period, the individual cannot exercise at the designated level, a lower speed and/or grade may be selected in keeping with the exercise capacity estimate. The individual should be monitored by electrocardiogram throughout the exercise and representative strips taken to provide heart rate in each minute of exercise. During the 5th or 6th minute of exercise, an arterial blood gas sample should be drawn and analyzed for PO_2 , PCO_2 , and pH. If the facility has the capability, and at the option of the DDS and the facility, minute ventilation (BTPS) and oxygen consumption per minute (STPD) and CO_2 production (STPD) should be measured during the 5th or 6th minute of exercise. If the individual fails to complete 6 minutes of exercise, the facility should comment on the reason.

The report should contain representative strips of electrocardiograms taken during the exercise, hematocrit, resting and exercise arterial blood gas value, speed and grade of the treadmill or bicycle ergometer exercise level in watts or kgm./min., and duration of exercise. The altitude of the test site, barometric pressure, and normal range of blood gas values for that facility should also be reported.

3. *Evaluation.* Three tables are provided in Listing 3.02C1 for evaluation of arterial blood gas determinations at rest and during exercise. The blood gas levels in Listing 3.02C1, Table III-A, are applicable at test sites situated at less than 3,000 feet above sea level. The blood gas levels in

Listing 3.02C1, Table III-B, are applicable at test sites situated at 3,000 through 6,000 feet above sea level. The blood gas levels in Listing 3.02C1, Table III-C, are applicable for test sites over 6,000 feet above sea level. Tables III-B and C, take into account the lower blood PaO_2 normally found in individuals tested at the higher altitude. When the barometric pressure is unusually high for the altitude at the time of testing, consideration should be given to those cases in which the PaO_2 falls slightly above the requirements of Table III-A, III-B, or III-C, whichever is appropriate for the altitude at which testing was performed.

3.01 Category of Impairments, Respiratory

3.02 *Chronic Pulmonary Insufficiency.*

With:

A. Chronic obstructive pulmonary disease (due to any cause). With: Both FEV_1 and MVV equal to or less than values specified in Table I corresponding to the person's height without shoes.

Table I

Height without shoes (inches)	FEV ₁ and MVV	
	Equal to or (L, BTPS)	(MBC) equal to or less than (L/min., BTPS)
60 or less	1.0	40
61-63	1.1	44
64-65	1.2	48
66-67	1.3	52
68-69	1.4	56
70-71	1.5	60
72 or more	1.6	64

or

B. *Chronic restrictive ventilatory disorders.* With: Total vital capacity equal to or less than values specified in Table II corresponding to the person's height without shoes. In severe kyphoscoliosis, the measured span between the fingertips when the upper extremities are abducted 90 degrees should be substituted for height.

Table II

Height without shoes (inches)	VC equal to or less than (L, BTPS)
60 or less	1.2
61-63	1.3
64-65	1.4
66-67	1.5
68-69	1.6
70-71	1.7
72-or more	1.8

or

C. Chronic impairment of gas exchange (due to any cause). With:

1. Stead-state exercise blood gases demonstrating values of PaO_2 and simultaneously determined PaCO_2 , measured at a workload of approximately 17 ml. $\text{O}_2/\text{kg.}/\text{min.}$ or less of exercise, equal to or less than the values specified in Table III-A or III-B or III-C.

Table III - A

[Applicable at test sites less than, 3,000 feet above sea level]

Arterial PCO ₂ (mm. Hg)	Arterial PO ₂ and equal to or less than (mm. Hg)
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40 or above	55

Table III - B

[Applicable at test sites 3,000 through 6,000 feet above sea level]

Arterial PCO ₂ (mm. Hg)	Arterial PCO ₂ and equal to or less than (mm. Hg)
30 or below	60
31	59
32	58
33	57
34	56
35	55
36	54
37	53
38	52
39	51
40 or above	50

Table III - C

[Applicable at test sites over 6,000 feet above sea level]

Arterial PCO ₂ (mm. Hg)	Arterial PO ₂ and equal to or less than (mm. Hg)
30 or below	56
31	54
32	53
33	52
34	51
35	50
36	49
37	48
38	47
39	46
40 or above	45

or

2. Diffusing capacity for the lungs for carbon monoxide less than 6 ml./mm. Hg/min. (steady-state methods) or less than 9 ml./mm. Hg/min. (single breath method) or less than 30 percent of predicted normal. (All method, actual values, and predicted normal values for the methods used should be reported.): or

D. Mixed obstructive ventilatory and gas exchange impairment. Evaluate under the criteria in 3.02A, B, and C.

3.03 Asthma. With:

A. Chronic asthmatic bronchitis. Evaluate under the criteria for chronic obstructive ventilatory impairment in 3.02A, or

B. Episodes of severe attacks (See 3.00C), in spite of prescribed treatment, occurring at least once every 2 months or on an average of at least 6 times a year, and prolonged expiration with wheezing or rhonchi on physical examination between attacks.

3.06 *Pneumoconiosis (demonstrated by roentgenographic evidence)*. Evaluate under criteria in 3.02.

3.07 *Bronchiectasis (demonstrated by radio-opaque material)*. With:

A. Episodes of acute bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum) occurring at least every 2 months; or

B. Impairment of pulmonary function due to extensive disease should be evaluated under the applicable criteria in 3.02.

3.08 *Mycobacterial infection of the lung*. Impairment of pulmonary function due to extensive disease should be evaluated under appropriate criteria in 3.02.

3.09 *Mycotic infection of the lung*. Impairment of pulmonary function due to extensive disease should be evaluated under the appropriate criteria in 3.02.

3.11 *Cor pulmonale, or pulmonary vascular hypertension*. Evaluate under the criteria in 4.02D.

4.00 CARDIOVASCULAR SYSTEM

A. *Severe cardiac impairment* results from one or more of three consequences of heart disease; (1) congestive heart failure; (2) ischemia (with or without necrosis) of heart muscle; (3) conduction disturbances and/or arrhythmias resulting in cardiac syncope.

With diseases of arteries and veins, severe impairment may result from disorders of the vasculature in the central nervous system, eyes, kidneys, extremities, and other organs.

The criteria for evaluating impairment resulting from heart diseases or diseases of the blood vessels are based on symptoms, physical signs and pertinent laboratory findings.

B. *Congestive heart failure* is considered in the Listing under one category whatever the etiology (i.e., arteriosclerotic, hypertensive, rheumatic, pulmonary, congenital, or other organic heart diseases). Congestive heart failure is not considered to have been established for the purpose of 4.02 unless there is evidence of vascular congestion such as hepatomegaly or peripheral or pulmonary edema which is consistent with clinical diagnosis. (Radiological description of vascular congestion, unless supported by appropriate clinical evidence, should not be construed as pulmonary edema.) The findings of vascular congestion need not be present at the time of adjudication (except for 4.02A), but must be casually related to the current episode of marked impairment. The findings other than vascular congestion must be persistent.

Other congestive, ischemic, or restrictive (obstructive) heart diseases such as caused by cardiomyopathy or aortic stenosis may result in significant impairment due [sic] to congestive heart failure, rhythm disturbances, or ventricular outflow obstruction in the absence of left ventricular enlargement as described in 4.02B1. However, the ECG criteria as defined in 4.02B2 should be fulfilled. Clinical findings such as symptoms [sic] of dyspnea, fatigue, rhythm disturbances, etc., should be documented and the diagnosis confirmed by echocardiography or at cardiac catheterization.

C. *Hypertensive vascular diseases* does not result in severe impairment unless it causes severe damage to one or more of four end organs; heart, brain, kidneys, or eyes. (retinae). The presence of such damage must be established by appropriate abnormal physical signs and laboratory findings as specified in 4.02 or 4.04, or for the body system involved.

D. *Ischemic heart diseases* may result in a marked impairment due to chest pain. Description of the pain must

contain the clinical characteristics as discussed under 4.00E. In addition, the clinical impression of chest pain of cardiac origin must be supported by objective evidence as described under 4.00 F, G, or H.

E. *Chest pain of cardiac origin* is considered to be pain which is precipitated by effort and promptly relieved by sublingual nitroglycerin or rapid-acting nitrates or rest. The character of the pain is classically described as crushing squeezing, burning, or oppressive pain located in the chest. Excluded is sharp, sticking or rhythmic pain. Pain occurring on exercise should be described specifically as to usual inciting factors (kind and degree), character, location, radiation, duration, and responses to nitroglycerin or rest.

So-called "anginal equivalent" locations manifested by pain in the throat, arms, or hands have the same validity as the chest pain described above. Status anginosus and variant angina of the Prinzmetal type (e.g., rest angina with transitory ST elevation on electrocardiogram) will be considered to have the same validity as classical angina pectoris as described above. Shortness of breath as an isolated finding should not be considered as an anginal equivalent.

Chest pain that appears to be of cardiac origin may be caused by noncoronary conditions. Evidence for the latter should be actively considered in determining whether the chest pain is of cardiac origin. Among the more common conditions which may masquerade as angina are gastrointestinal tract lesions such as biliary tract disease, esophagitis, hiatal hernia, peptic ulcer, and pancreatitis; and musculoskeletal lesions such as costochondritis and cervical arthritis.

F. *Documentation of electrocardiography.*

1. *Electrocardiograms obtained at rest* must be submitted in the original or a legible copy of a 12-lead tracing

appropriately labeled, with the standardization inscribed on the tracing. Alteration in standardization of specific leads (such as to accommodate large QRS amplitudes) must be shown on those leads.

The effect of drugs, electrolyte imbalance, etc., should be considered as possible noncoronary causes of ECG abnormalities, especially those involving the ST segment. If needed and available, pre-drug (especially predigitalis) tracing should be obtained.

The term "ischemic" is used in 4.04 to describe a pathologic ST deviation. Nonspecific repolarization changes should not be confused with ischemic configurations or a current of injury.

Detailed descriptions or computer interpretations without the original or legible copies of the ECG are not acceptable.

2. *Electrocardiograms obtained in conjunction with exercise tests* must include the original tracings or a legible copy of appropriate leads obtained before, during, and after exercise. Test control tracings, taken before exercise. Test control tracings, taken before exercise in the upright position, must be obtained. An ECG after 20 seconds of vigorous hyperventilation should be obtained. A post-hyperventilation tracing may be essential for the proper evaluation of an "abnormal" test in certain circumstances, such as in women with evidence of mitral valve prolapse. A tracing should be taken at approximately 5 METs of exercise and at the time the ECG becomes abnormal according to the criteria in 4.04A. The time of onset of these abnormal changes must be noted, and the ECG tracing taken at the time should be obtained. Exercise histograms without the original tracings or legible copies are not acceptable.

Whenever electrocardiographically documented stress test data are submitted, irrespective of the type, the stand-

ardization must be inscribed on the tracings and the strips must be labeled appropriately, indicating the times recorded. The degree of exercise achieved, the blood pressure levels during the test, and any reason for terminating the test must be included in the report.

G. Exercise testing.

1. *When to purchase.* Since the results of a treadmill exercise test are the primary basis for adjudicating claims under 4.04, they should be included in the file whenever they have been performed. There are also circumstances under which it will be appropriate to purchase exercise tests. Generally, these are limited to claims involving chest pain which is considered to be of cardiac origin but without corroborating ECG or other evidence of ischemic heart disease.

Exercise test should not be purchased in the absence of alleged chest pain of cardiac origin. Even in the presence of an allegation of chest pain of cardiac origin, an exercise test should not be purchased where full development short of such a purchase reveals that the impairment meets or equals any Listing or the claim can be adjudicated on some other basis.

2. *Methodology.* When an exercise test is purchased, it should be a treadmill type using a continuous progressive multistage regimen. The targeted heart rate should be not less than 85 percent of the maximum predicted heart rate unless it becomes hazardous to exercise to the heart rate or becomes unnecessary because the ECG meets the criteria in 4.04A at a lower heart rate (see also 4.00F.2). Beyond these requirements, it is prudent to accept the methodology of a qualified, competent test facility. In any case, a precise description of the protocol that was followed must be provided.

3. *Limitations of exercise testing.* Exercise testing should not be purchased for individuals who have the fol-

lowing: unstable progressive angina pectoris; recent onset (approximately 2 months) of angina; congestive heart failure; uncontrolled serious arrhythmias (including uncontrolled auricular fibrillation); second or third-degree heart block; Wolff-Parkinson-White syndrome; uncontrolled marked hypertension; marked aortic stenosis; marked pulmonary hypertension; dissecting or ventricular aneurysms; acute illness; limiting neurological or musculoskeletal impairments; or for individuals on medication where performance of stress testing may constitute a significant risk.

The presence of noncoronary or nonischemic factors which may influence the ECG response to exercise include hypokalemia, hyperventilation, vasoregulatory asthenia, significant anemia, left bundle branch block, and other heart disease, particularly valvular.

Digitalis may cause ST segment abnormalities at rest, during, and after exercise. Digitalis-related ST depression, present at rest, may become accentuated and result in false interpretations of the ECG taken during or after exercise test.

4. *Evaluation.* Where the evidence includes the results of a treadmill exercise test, this evidence is the primary basis for adjudicating claims under 4.04. For purposes of this Social Security disability program, treadmill exercise testing will be evaluated on the basis of the level at which the test becomes positive in accordance with the ECG criteria in § 404A. However, the significance of findings of a treadmill exercise test must be considered in light of the clinical course of the disease which may have occurred subsequent to performance of the exercise test. The criteria in 4.04B are not applicable if there is documentation of an acceptable treadmill exercise test, it [sic] there is no evidence of a treadmill exercise test or if the test is not acceptable, the criteria in 4.04B should be used. The

level of exercise is considered in terms of multiples of MET's (metabolic equivalent units). One MET is the basal O_2 requirement of the body in an inactive state, sitting quietly [sic]. It is considered by most authorities to be approximately 3.5 ml. O_2 /kg./min.

H. *Angiographic evidence.*

1. *Coronary arteriography.* This procedure is not to be purchased by the Social Security Administration. Should the results of such testing be available, the report should be considered as to the quality and kind of data provided and its applicability to the requirements of the Listing of Impairments. A copy of the report of the catheterization and ancillary studies should be obtained. The report should provide information as to the technique used, the method of assessing coronary lumen diameter, and the nature and location of any obstructive lesions.

It is helpful to know the method used, the number of projections, and whether selective engagement of each coronary vessel was satisfactorily accomplished. It is also important to know whether the injected vessel was entirely and uniformly opacified, thus avoiding the artifactual appearance of narrowing or an obstruction.

Coronary artery spasm induced by intracoronary catheterization is not to be considered as evidence of ischemic heart disease.

Estimation of the functional significance of an obstructive lesion may also be aided by description of how well the distal part of the vessel is visualized. Some patients with significant proximal coronary atherosclerosis have well-developed large collateral blood supply to the distal vessels without evidence of myocardial damage or ischemia, even under conditions of severe stress.

2. *Left ventriculography.* The report should describe the local contractility of the myocardium as may be evident from areas of hypokinesia, dyskinesia, or akinesia;

and the overall contractility of the myocardium as measured by the ejection fraction.

3. *Proximal coronary arteries* (see 4.04B7) will be considered as the:

- a. Right coronary artery proximal to the acute marginal branch; or
- b. Left anterior descending coronary artery proximal to the first septal perforator; or
- c. Left circumflex coronary artery proximal to the first obtuse marginal branch.

1. *Results of other tests.* Information from adequate reports of other tests such as radionuclide studies or echocardiography should be considered where that information is comparable to the requirements in the listing. An ejection fraction measured by echocardiography is not determinative, but may be given consideration in the context of associated findings.

J. *Major surgical procedures.* The amount of function restored and the time required to effect improvement after heart or vascular surgery vary with the nature and extent of the disorder, the type of surgery, and other individual factors. If the criteria described for heart or vascular disease are met, proposed heart or vascular surgery (coronary artery bypass procedure, valve replacement, major arterial grafts, etc.) does not militate against a finding of disability with subsequent assessment postoperatively.

The usual time after surgery for adequate assessment of the results of surgery is considered to be approximately 3 months. Assessment of the magnitude of the impairment following surgery requires adequate documentation of the pertinent evaluations and tests performed following surgery, such as an interval history and physical examination, with emphasis on those signs and symptoms which might have changed postoperatively, as well as X-rays and electrocardiograms. Where treadmill exercise tests or

angiography have been performed following the surgical procedure, the results of these tests should be obtained.

Documentation of the preoperative evaluation and a description of the surgical procedure are also required. The evidence should be documented from hospital records (catheterization reports, coronary arteriographic reports, etc.) and the operative note.

Implantation of a cardiac pacemaker is not considered a major surgical procedure for purposes of this section.

K. *Evaluation of peripheral arterial disease.* The evaluation of peripheral arterial disease is based on medically acceptable clinical findings providing adequate history and physical examination findings describing the impairment, and on documentation of the appropriate laboratory techniques. The specific findings stated in Listing 4.13 represent the level of severity of that impairment; these findings, by themselves, are not intended to represent the basis for establishing the clinical diagnosis. The level of the impairment is based on the symptomatology, physical findings, Doppler studies before and after a standard exercise test, and/or angiographic findings.

The requirements for evaluation of peripheral arterial disease in Listing 4.13B are based on the ratio of systolic blood pressure at the ankle, determined by Doppler study, to the systolic blood pressure at the brachial artery determined at the same time. Results of plethysmographic studies, or other techniques providing systolic blood pressure determinations at the ankle, should be considered where the information is comparable to the requirements in the listing.

Listing 4.13B.1 providing for determining that the listing is met when the resting ankle/brachia systolic blood pressure ratio is less than 0.50. Listing 4.13B.2 provides additional criteria for evaluating peripheral arterial impairment on the basis of exercise studies when the resting

ankle/brachial systolic blood pressure ratio is 0.50 or above. The results of exercise studies should describe the level of exercise (e.g., speed and grade of the treadmill settings), the duration of exercise, symptoms during exercise, the reasons for stopping exercise if the expected level of exercise was not attained, blood pressures at the ankle and other pertinent levels measured after exercise, and the time required to return the systolic blood pressure toward or to, the preexercise level. When exercise Doppler studies are purchased by the Social Security Administration, it is suggested that the requested exercise be on a treadmill at 2 mph. on a 12 percent grade for 5 minutes. Exercise studies should not be performed on individuals for whom exercise is contraindicated. The methodology of a qualified, competent facility should be accepted. In any case, a precise description of the protocol that was followed must be provided.

It must be recognized that application of the criteria in Listing 4.13B may be limited in individuals who have severe calcific (Monckeberg's) sclerosis of the peripheral arteries or severe small vessel disease in individuals with diabetes mellitus.

4.01 Category of Impairments, Cardiovascular System.

4.02 *Congestive heart failure (manifested by evidence of vascular congestion such as hepatomegaly, peripheral or pulmonary edema).* With:

A. Persistent congestive heart failure on clinical examination despite prescribed therapy; or

B. Persistent left ventricular enlargement and hypertrophy documented by both:

1. Extension of the cardiac shadow (left ventricle) to the vertebral column on a left lateral chest roentgenogram; and

2. ECG showing QRS duration less than 0.12 second with S_{V1} plus R_{V5} (or R_{V6}) of 35 mm. or greater *and* ST segment depressed more than 0.5 mm. *and* low, diphasic or inverted T waves in leads with all tall R waves; or

C. Persistent "mitral" type heart involvement documented by left atrial enlargement shown by double shadow on PA chest roentgenogram (or characteristic distortion of barium-filled esophagus) and either;

1. ECG showing QRS duration less than 0.12 second with S_{V1} plus R_{V5} (or R_{V6}) of 35 mm. or greater *and* ST segment depressed more than 0.5 mm. *and* low, diphasic or inverted T waves in leads with tall R waves; or

2. ECG evidence of right ventricular hypertrophy with R wave of 5.0 mm. or greater in lead V_1 *and* progressive decrease in R/S amplitude from lead V_1 to V_5 or V_6 ; or

D. Cor pulmonale (non-acute) documented by both:

1. Right ventricular enlargement (or prominence of the right out-flow trace) on chest roentgenogram or fluoroscopy; and

2. ECG evidence of right ventricular hypertrophy with R wave of 5.0 mm. or greater in lead V_1 *and* progressive decrease in R/S amplitude from lead V_1 to V_5 or V_6 .

4.03 *Hypertensive vascular disease.* Evaluate under 4.02 04 4.04 or under the criteria for the affected body system.

4.04 *Ischemic heart disease with chest pain or cardiac origin as described in 4.00E* With:

A. Treadmill exercise test (see 4.00 F and (G) demonstrating one of the following at an exercise level of 5 METs or less:

1. Horizontal or downsloping depression (from the standing control) of the ST segment to 1.0 mm. or greater, lasting for at least 0.08 second after the J junction, and clearly discernible in at least two consecutive complexes which are on a level baseline in any lead; or

2. Junctional depression occurring during exercise, remaining depressed (from the standing control) to 2.0 mm. or greater for at least 0.08 second after the J junction (the so called slow upsloping ST segment), and clearly discernible in at least two consecutive complexes which are on a level baseline in any lead; or

3. Premature ventricular systoles which are multiform or bidirectional or are sequentially inscribed (3 or more); or

4. ST segment elevation (from the standing control) to 1 mm. or greater; or

5. Development of second or third degree heart block; or

B. In the absence of a report of an acceptable treadmill exercise test (see 4.00G), one of the following:

1. Transmural myocardial infarction exhibiting a QS pattern or a Q wave with amplitude at least $\frac{1}{3}$ rd of R wave and with a duration of 0.04 second or more. (If these are present in leads III and a VF only, the requisite Q wave findings must be shown, by labelled tracing, to persist on deep inspiration); or

2. Resting ECG findings showing ischemic-type (see § 4.00F1) depression of ST segment to more than 0.5 mm. in either (a) leads I and a VL and V_6 or (b) leads II and III and a VF or (c) leads V_3 through V_6 ; or

3. Resting ECG findings showing an ischemic configuration or current of injury (see 4.00F1) with ST segment elevation to 2 mm. or more in either (a) leads I and a VL and V_6 or (b) leads II and III and a VF or (c) leads V_3 through V_6 ; or

4. Resting ECG findings show symmetrical inversion of T waves to 5.0 mm. or more in any two leads except leads III or a VR or V_1 or V_2 ; or

5. Inversion of T wave to 1.0 mm. or more in any of leads I, II, aVL, V_2 to V_6 *and* R wave of 5.0 mm. or more

in lead aVL *and* R wave greater than S wave in lead aVF;
or

6. "Double" Master Two-Step test demonstrating one of the following:

a. Ischemic depression of ST segment to more than 0.5 mm. lasting for at least 0.08 second beyond the J junction and clearly discernible in at least two consecutive complexes which are on a level baseline in any lead; or

b. Development of a second or third degree heart block; or

7. Angiographic evidence (see 4.00H) (obtained independent of Social Security disability evaluation) showing one of the following:

a. 50 percent or more narrowing of the left main coronary artery; or

b. 70 percent or more narrowing of a *proximal* coronary artery (see 4.00H3) (excluding the left main coronary artery); or

c. 50 percent or more narrowing involving a long (greater than 1 cm.) segment of a proximal coronary artery or multiple proximal coronary arteries; or

8. Akinetic or hypokinetic myocardial wall or septal motion with left ventricular ejection fraction of 30 percent or less measured by contrast or radio-isotopic ventriculographic methods; or

C. Resting ECG findings showing left bundle branch block as evidenced by QRS duration of 0.12 second or more in leads I, II, or III *and* R peak duration of 0.06 second or more in leads I, aVL, V₅, or V₆, unless there is a coronary angiogram of record which is negative (see criteria in 4.04B7).

4.05 *Recurrent arrhythmias* (not due to digitalis toxicity) resulting in uncontrolled repeated episodes of cardiac syncope and documented by resting or ambulatory (Holter) electrocardiography.

4.09 *Myocardopathies, rheumatic or syphilitic heart disease*. Evaluate under the criteria in 4.02, 4.04, 4.05, or 11.04.

4.1i *Aneurysm of aorta or major branches* (demonstrated by roentgenographic evidence). With:

A. Acute or chronic dissection not controlled by prescribed medical or surgical treatment; or

B. Congestive heart failure as described under the criteria in 4.02; or

C. Renal failure as described under the criteria in 6.02; or

D. Repeated syncopal episodes.

4.12 *Chronic venous insufficiency* of the lower extremity with incompetency or obstruction of the deep venous return, associated with superficial varicosities, extensive brawny edema, stasis dermatitis, and recurrent or persistent ulceration which has not healed following at least 3 months of prescribed medical or surgical therapy.

4.13 *Peripheral arterial disease*. With:

A. Intermittent claudication with failure to visualize (on arteriogram obtained independent of Social Security disability evaluation) the common femoral or deep femoral artery in one extremity; or

B. Intermittent claudication with marked impairment of peripheral arterial circulation as determined by Doppler studies showing:

1. Resting ankle/brachial systolic blood pressure ratio of less than 0.50; or

2. Decrease in systolic blood pressure at ankle or exercise (see 4.00K) to 50 percent or more of preexercise level *and* requiring 10 minutes or more to return to preexercise [sic] level; or

C. Amputation at or above the tarsal region due to peripheral arterial disease.

5.00 DIGESTIVE SYSTEM

A. *Disorders of the digestive system* which result in a marked impairment usually do so because of interference with nutrition, multiple recurrent inflammatory lesions, or complications of disease, such as fistulae, abscesses, or recurrent obstruction. Such complications usually respond to treatment. These complications must be shown to persist on repeated examinations despite therapy for a reasonable presumption to be made that a marked impairment will last for a continuous period of at least 12 months.

B. *Malnutrition or weight loss from gastrointestinal disorders.* When the primary disorder of the digestive tract has been established (e.g. enterocolitis, chronic pancreatitis, postgastrointestinal resection, or esophageal stricture, stenosis, or obstruction), the resultant interference with nutrition will be considered under the criteria in 5.08. This will apply whether the weight loss is due to primary or secondary disorders of malabsorption, malassimilation or obstruction. However, weight loss not due to diseases of the digestive tract, but associated with psychiatric or primary endocrine or other disorders, should be evaluated under the appropriate criteria for the underlying disorder.

C. *Surgical diversion of the intestinal tract*, including colostomy or ileostomy, are not listed since they do not represent impairments which preclude all work activity if the individual is able to maintain adequate nutrition and function of the stoma. Dumping syndrome which may follow gastric resection rarely represents a marked impairment which would continue for 12 months. Peptic ulcer disease with recurrent ulceration after definitive surgery ordinarily responds to treatment. A recurrent ulcer after definitive surgery must be demonstrated on repeated upper gastrointestinal roentgenograms or gastroscopic ex-

aminations despite therapy to be considered a severe impairment which will last for at least 12 months. Definitive surgical procedures are those designed to control the ulcer disease process (i.e., vagotomy and pyloroplasty, subtotal gastrectomy, etc.). Simple closure of a perforated ulcer does not constitute definitive surgical therapy for peptic ulcer disease.

5.01 Category of Impairments, Digestive System

5.02 *Recurrent upper gastrointestinal hemorrhage from undetermined cause* with anemia manifested by hematocrit of 30 percent or less on repeated examinations.

5.03 *Stricture, stenosis, or obstruction of the esophagus (demonstrated by X-ray or endoscopy)* with weight loss as described under § 5.08.

5.04 *Peptic ulcer disease (demonstrated by X-ray or endoscopy).* With:

A. Recurrent ulceration after definitive surgery persistent despite therapy; or

B. Inoperable fistula formation; or

C. Recurrent obstruction demonstrated by X-ray or endoscopy. [sic] or

D. Weight loss as described under § 5.08.

5.05 *Chronic liver disease (e.g., portal, postnecrotic, or biliary cirrhosis; chronic active hepatitis; Wilson's disease).* With:

A. Esophageal varices (demonstrated by X-ray or endoscopy) with a documented history of massive hemorrhage attributable to these varices. Consider under a disability for 3 years following the last massive hemorrhage; thereafter, evaluate the residual impairment; or

B. Performance of a shunt operation for esophageal varices. Consider under a disability for 3 years following surgery; thereafter, evaluate the residual impairment; or

C. Serum bilirubin of 2.5 mg. per deciliter (100 ml.) or greater persisting on repeated examinations for at least 5 months; or

D. Ascites, not attributable to other causes, recurrent or persisting for at least 5 months, demonstrated by abdominal paracentesis or associated with persistent hypoalbuminemia of 3.0 gm. per deciliter (100 ml.) or less; or

E. Hepatic encephalopathy. Evaluate under the criteria in listing 12.02; or

F. Confirmation of chronic liver disease by liver biopsy (obtained independent of Social Security disability evaluation) and one of the following:

1. Ascites not attributable to other causes, recurrent or persisting for at least 3 months, demonstrated by abdominal paracentesis or associated with persistent hypoalbuminemia of 3.0 gm. per deciliter (100 ml.) or less; or

2. Serum bilirubin of 2.5 mg. per deciliter (100 ml) or greater on repeated examinations for at least 3 months; or

3. Hepatic cell necrosis or inflammation, persisting for at least 3 months, documented by repeated abnormalities of prothrombin time and enzymes indicative of hepatic dysfunction.

5.06 *Chronic ulcerative or granulomatous colitis (demonstrated by endoscopy, barium enema, biopsy, or operative findings).* With:

A. Recurrent bloody stools documented on repeated examinations and anemia manifested by hematocrit of 30 percent or less on repeated examinations; or

B. Persistent or recurrent systemic manifestations, such as arthritis, iritis, fever, or liver dysfunction, not attributable to other causes; or

C. Intermittent obstruction due to intractable abscess, fistula formation, or stenosis; or

D. Recurrence of findings of A, B, or C above after total colectomy; or

E. Weight loss as described under § 5.08.

5.07 *Regional enteritis (demonstrated by operative findings, barium studies, biopsy, or endoscopy).* With:

A. Persistent or recurrent intestinal obstruction evidenced by abdominal pain, distention, nausea, and vomiting and accompanied by stenotic areas of small bowel with proximal intestinal dilation; or

B. Persistent or recurrent systemic manifestations such as arthritis, iritis, fever, or liver dysfunction, not attributable to other causes; or

C. Intermittent obstruction due to intractable abscess or fistula formation; or

D. Weight loss as described under § 5.08.

5.08 *Weight loss due to any persisting gastrointestinal disorder:* (The following weights are to be demonstrated to have persisted for at least 3 months despite prescribed therapy and expected to persist at this level for at least 12 months.) With:

A. Weight equal to or less than the values specified in Table I or II; or

B. Weight equal to or less than the values specified in Table III or IV and one of the following abnormal findings on repeated examinations:

1. Serum albumin of 3.0 gm. per deciliter (100 ml.) or less; or

2. Hematocrit of 30 percent or less; or

3. Serum calcium of 8.0 mg. per deciliter (100 ml.) (4.0 mEq./L) or less; or

4. Uncontrolled diabetes mellitus due to pancreatic dysfunction with repeated hyperglycemia, hypoglycemia, or ketosis; or

5. Fat in stool of 7 gm. or greater per 24-hour stool specimen; or

6. Nitrogen in stool of 3 gm, [sic] or greater per 24-hour specimen; or

7. Persistent or recurrent ascites or edema not attributable to other causes.

Tables of weight reflecting malnutrition scaled according to height and sex — To be used only in connection with 5.08.

Table I — Men

Height (inches) ¹	Weight (pounds)
61	90
62	92
63	94
64	97
65	99
66	102
67	106
68	109
69	112
70	115
71	118
72	122
73	125
74	128
75	131
76	134

¹ Height measured without shoes.

Table II — Women

Height (inches) ¹	Weight (pounds)
58	77
59	79
60	82

Table II — Women — Continued

Height (inches) ¹	Weight (pounds)
61	84
62	86
63	89
64	91
65	94
66	98
67	101
68	104
69	107
70	110
71	114
72	117
73	120

¹ Height measured without shoes.

Table III — Men

Height (inches) ¹	Weight (pounds)
61	95
62	98
63	100
64	103
65	106
66	109
67	112
68	116
69	119
70	122
71	126
72	129

Table III — Men — Continued

Height (inches) ¹	Weight (pounds)
73	133
74	136
75	139
76	143

¹ Height measured without shoes.

Table IV — Women

Height (inches) ¹	Weight (pounds)
58	82
59	84
60	87
61	89
62	92
63	94
64	97
65	100
66	104
67	107
68	111
69	114
70	117
71	121
72	124
73	128

¹ Height measured without shoes.

6.00 GENITO-URINARY SYSTEM

A. *Determination of the presence of chronic renal disease will be based upon* (1) a history, physical examination, and laboratory evidence of renal disease, and (2) indications of its progressive nature or laboratory evidence of deterioration or renal function.

B. *Nephrotic Syndrome.* The medical evidence establishing the clinical diagnosis must include the description of extent of tissue edema, including pretibial, periorbital, or presacral edema. The presence of ascites, pleural effusion, pericardial effusion, and hydroarthrosis should be described if present. Results of pertinent laboratory tests must be provided. If a renal biopsy has been performed, the evidence should include a copy of the report of microscopic examination of the specimen. Complications such as severe orthostatic hypotension, recurrent infections or venous thromboses should be evaluated on the basis of resultant impairment.

C. *Hemodialysis, peritoneal dialysis, and kidney transplantation.* When an individual is undergoing periodic dialysis because of chronic renal disease, severity of impairment is reflected by the renal function prior to the institution of dialysis.

The amount of function restored and the time required to effect improvement in an individual treated by renal transplant depend upon various factors, including adequacy of post transplant renal function, incidence and severity of renal infection, occurrence of rejection crisis, the presence of systemic complications (anemia, neuropathy, etc.) and side effects of corticosteroids or immunosuppressive agents. A convalescent period of at least 12 months is required before it can be reasonably determined whether the individual has reached a point of stable medical improvement.

D. *Evaluate associated disorders and complications according to the appropriate body system Listing.*

6.01 Category of Impairments, Genito-Urinary System

6.02 Impairment of renal function, due to any chronic renal disease expected to last 12 months (e.g., hypertensive vascular disease, chronic nephritis, nephrolithiasis, polycystic disease, bilateral hydronephrosis, etc.) With:

A. Chronic hemodialysis or peritoneal dialysis necessitated by irreversible renal failure; or

B. Kidney transplant. Consider under a disability for 12 months following surgery; thereafter, evaluate the residual impairment (see 6.00C); or

C. Persistent elevation of serum creatine in to 4 mg. per deciliter (100 ml.) or greater or reduction of creatinine clearance to 20 ml. per minute (29 liters/24 hours) or less, over at least 3 months, with one of the following:

1. Renal osteodystrophy manifested by severe bone pain and appropriate radiographic abnormalities (e.g., osteitis fibrosa, marked osteoporosis, pathologic fractures); or

2. A clinical episode of pericarditis; or

3. Persistent motor or sensory neuropathy; or

4. Intractable pruritus; or

5. Persistent fluid overload syndrome resulting in diastolic hypertension (110 mm. or above) or signs of vascular congestion; or

6. Persistent anorexia with recent weight loss and current weight meeting the values in 5.08, Table III or IV; or

7. Persistent hematocrits of 30 percent or less.

6.06 *Nephrotic syndrome, with significant anasarca, persistent for at least 3 months despite prescribed therapy.* With:

A. Serum albumin of 3.0 gm. per deciliter (100 ml.) or less and proteinuria of 3.5 gm. per 24 hours or greater; or

B. Proteinuria of 10.0 gm. per 24 hours or greater.

7.00 HEMIC AND LYMPHATIC SYSTEM

A. *Impairment caused by anemia* should be evaluated according to the ability of the individual to adjust to the reduced oxygen carrying capacity of the blood. A gradual reduction in red cell mass, even to very low values, is often well tolerated in individuals with a healthy cardiovascular system.

B. *Chronicity is indicated by persistence* of the condition for at least 3 months. The laboratory findings cited must reflect the values reported on more than one examination over that 3-month period.

C. *Sickle cell disease* refers to a chronic hemolytic anemia associated with sickle cell hemoglobin, either homozygous or in combination with thalassemia or with another abnormal hemoglobin (such as C or F).

Appropriate hematologic evidence for sickle cell disease, such as hemoglobin electrophoresis, must be included. Vasoocclusive or aplastic episodes should be documented by description of severity, frequency, and duration.

Major visceral episodes include meningitis, osteomyelitis, pulmonary infections or infarctions, cerebrovascular accidents, congestive heart failure, genito-urinary involvement, etc.

D. *Coagulation defects.* Chronic inherited coagulation disorders must be documented by appropriate laboratory evidence. Prophylactic therapy such as with anti-hemophilic globulin (AHG) concentrate does not in itself imply severity.

E. *Acute leukemia.* Initial diagnosis of acute leukemia must be based upon definitive bone marrow pathologic evidence. Recurrent disease may be documented by peripheral blood, bone marrow, or cerebrospinal fluid examination. The pathology report must be included.

The acute phase of chronic myelocytic (granulocytic) leukemia should be considered under the requirements for acute leukemia.

The criteria in 7.11 contain the designated duration of disability implicit in the finding of a listed impairment. Following the designated time period, a documented diagnosis itself is no longer sufficient to establish a marked impairment. The level of any remaining impairment must be evaluated on the basis of the medical evidence.

7.01 Category of Impairments, Hemic and Lymphatic System

7.02 *Chronic anemia (hematocrit persisting at 30 percent or less due to any cause).* With:

A. Requirement of one or more blood transfusions on an average of at least once every 2 months; or

B. Evaluation of the resulting impairment under criteria for the affected body system.

7.05 *Sickle cell disease, or one of its variants.* With:

A. Documented painful (thrombotic) crises occurring at least three times during the 5 months prior to adjudication; or

B. Requiring extended hospitalization (beyond emergency care) at least three times during the 12 months prior to adjudication; or

C. Chronic, severe anemia with persistence of hematocrit of 26 percent or less; or

D. Evaluate the resulting impairment under the criteria for the affected body system.

7.06 *Chronic thrombocytopenia (due to any cause)* with platelet counts repeatedly below 40,000/cubic millimeter. With:

A. At least one spontaneous hemorrhage, requiring transfusion, within 5 months prior to adjudication; or

B. Intracranial bleeding within 12 months prior to adjudication.

7.07 *Hereditary telangiectasia* with hemorrhage requiring transfusion at least three times during the 5 months prior to adjudication.

7.08 *Coagulation defects (hemophilia or a similar disorder)* with spontaneous hemorrhage requiring transfusion at least three times during the 5 months prior to adjudication.

7.09 *Polycythemia vera (with erythrocytosis, splenomegaly, and leukocytosis or thrombocytosis).* Evaluate the resulting impairment under the criteria for the affected body system.

7.10 *Myelofibrosis (myeloproliferative syndrome).* With:

A. Chronic anemia. Evaluate according to the criteria of § 7.02; or

B. Documented recurrent systemic bacterial infections occurring at least 3 times during the 5 months prior to adjudication; or

C. Intractable bone pain with radiologic evidence of osteosclerosis.

7.11 *Acute leukemia.* Consider under a disability for 2½ years from the time of initial diagnosis.

7.12 *Chronic leukemia.* Evaluate according to the criteria of 7.02, 7.06, 7.10B, 7.11, 7.17 or 13.06A.

7.13 *Lymphomas.* Evaluate under the criteria in 13.06A.

7.14 *Macroglobulinemia or heavy chain disease,* confirmed by serum or urine protein electrophoresis or immunoelectrophoresis. Evaluate impairment under criteria for affected body system or under 7.02, 7.06, or 7.08.

7.15 *Chronic granulocytopenia (due to any cause).* With both A and B:

A. Absolute neutrophil counts repeatedly below 1,000 cells/cubic millimeter; and

B. Documented recurrent systemic bacterial infections occurring at least 3 times during the 5 months prior to adjudication.

7.16 *Myeloma (confirmed by appropriate serum or urine protein electrophoresis and bone marrow findings).*

With:

A. Radiologic evidence of bony involvement with intractable bone pain; or

B. Evidence of renal impairment as described in 6.02; or

C. Hypercalcemia with serum calcium levels persistently greater than 11 mg. per deciliter (100 ml.) for at least 1 month despite prescribed therapy; or

D. Plasma cells (100 or more cells/cubic millimeter) in the peripheral blood.

7.17 *Aplastic anemias or hematologic malignancies (excluding acute leukemia):* With bone marrow transplantation. Consider under a disability for 12 months following transplantation; thereafter, evaluate according to the primary characteristics of the residual impairment.

8.00 SKIN

A. *Skin lesions* may result in a marked, long-lasting impairment if they involve extensive body areas or critical areas such as the hands or feet and become resistant to treatment. These lesions must be shown to have persisted for a sufficient period of time despite therapy for a reasonable presumption to be made that a marked impairment will last for a continuous period of at least 12 months. The treatment for some of the skin diseases listed in this section may require the use of high dosage of drugs with possible serious side effects; these side effects should be considered in the overall evaluation of impairment.

B. *When skin lesions are associated with systemic disease* and where that is the predominant problem, evaluation should occur according to the criteria in the appropriate section. Disseminated (systemic) lupus erythematosus and scleroderma usually involve more than one body system and should be evaluated under 10.04 and 10.05. Neoplastic skin lesions should be evaluated under 13.00ff. When skin lesions (including burns) are associated with contractures or limitation of joint motion, that impairment should be evaluated under 1.00ff.

8.01 *Category of Impairments, Skin*

8.02 *Exfoliative dermatitis, ichthyosis, ichthyosiform erythroderma.* With extensive lesions not responding to prescribed treatment.

8.03 *Pemphigus, erythema multiforme bullosum, bullous pemphigoid, dermatitis herpetiformis.* With extensive lesions not responding to prescribed treatment.

8.04 *Deep mycotic infections.* With extensive fungating, ulcerating lesions not responding to prescribed treatment.

8.05 *Psoriasis, atopic dermatitis, dyshidrosis.* With extensive lesions, including involvement of the hands or feet which imposed a marked limitation of function and which are not responding to prescribed treatment.

8.06 *Hydradenitis suppurative, acne conglobata.* With extensive lesions involving the axillae or perineum not responding to prescribed medical treatment and not amenable to surgical treatment.

9.00 ENDOCRINE SYSTEM

Cause of impairment. Impairment is caused by overproduction or underproduction of hormones, resulting in structural or functional changes in the body. Where involvement of other organ systems has occurred as a result

of a primary endocrine disorder, these impairments should be evaluated according to the criteria under the appropriate sections.

9.01 Category of Impairments, Endocrine

9.02 *Thyroid Disorders*. With:

A. Progressive exophthalmos as measured by exophthalmometry; or

B. Evaluate the resulting impairment under the criteria for the affected body system.

9.03 *Hyperparathyroidism*. With:

A. Generalized decalcification of bone on X-ray study and elevation of plasma calcium to 11 mg. per deciliter (100 ml.) or greater; or

B. A resulting impairment. Evaluate according to the criteria in the affected body system.

9.04 *Hypoparathyroidism*. With:

A. Severe recurrent tetany; or

B. Recurrent generalized convulsions; or

C. Lenticular cataracts. Evaluate under the criteria in 2.00ff.

9.05 *Neurohypophyseal insufficiency (diabetes insipidus)*. With urine specific gravity of 1.005 or below, persistent for at least 3 months and recurrent dehydration.

9.06 *Hyperfunction of the adrenal cortex*. Evaluate the resulting impairment under the criteria for the affected body system.

9.08 *Diabetes mellitus*. With:

A. Neuropathy demonstrated by significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C); or

B. Acidosis occurring at least on the average of once every 2 months documented by appropriate blood chemical tests (pH or pCO₂ or bicarbonate levels); or

C. Amputation at, or above, the tarsal region due to diabetic necrosis or peripheral arterial disease; or

D. Retinitis proliferans; evaluate the visual impairment under the criteria in 2.02, 2.03, or 2.04.

10.00 MULTIPLE BODY SYSTEMS

A. The impairments included in this section usually involve more than a single body system.

B. Long-term obesity will usually be associated with disorders in the musculoskeletal, cardiovascular, peripheral vascular, and pulmonary systems, and the advent of such disorders is the major cause of impairment. Extreme obesity results in restrictions imposed by body weight and the additional restrictions imposed by disturbances in other body systems.

10.01 Category of Impairments, Multiple Body Systems

10.02 *Hansen's disease (leprosy)*. As active disease or consider as "under a disability" while hospitalized.

10.03 *Polyarteritis or perarteritis nodosa (established by biopsy)*. With signs of generalized arterial involvement.

10.04 *Disseminated lupus erythematosus (established by a positive LE preparation or biopsy or positive ANA test)*. With frequent exacerbations demonstrating involvement of renal or cardiac or pulmonary or gastrointestinal or central nervous systems.

10.05 *Scleroderma or progressive systemic sclerosis (the diffuse or generalized form)*. With:

A. Advanced limitation of use of hands due to sclerodactylia or limitation in other joints; or

B. Significant visceral manifestations of digestive, cardiac, or pulmonary impairment.

10.10 *Obesity*. Weight equal to or greater than the values specified in Table I for males, Table II for females

(100 percent above desired level) and one of the following:

A. History of pain and limitation of motion in any weight bearing joint or spine (on physical examination) associated with X-ray evidence or arthritis in a weight bearing joint or spine; or

B. Hypertension with diastolic blood pressure persistently in excess of 100 mm. Hg measured with appropriate size cuff; or

C. History of congestive heart failure manifested by past evidence of vascular congestion such as hepatomegaly, peripheral or pulmonary edema; or

D. Chronic venous insufficiency with superficial varicosities in a lower extremity with pain on weight bearing and persistent edema; or

E. Respiratory disease with total forced vital capacity equal to or less than 2.0 L. or a level of hypoxemia at rest equal to or less than the values specified in Table III-A or III-B or III-C.

Table I—Men

Height without shoes (inches) ¹	Weight (pounds)
60	246
61	252
62	258
63	264
64	270
65	276
66	284
67	294
68	302
69	310
70	318
71	328

Table I—Men—Continued

Height without shoes (inches) ¹	Weight (pounds)
72	336
73	346
74	356
75	364
76	374

Table II—Women

Height without shoes (inches) ¹	Weight (pounds)
56	208
57	212
58	218
59	224
60	230
61	236
62	242
63	250
64	258
65	266
66	274
67	282
68	290
69	298
70	306
71	314
72	322

Table III - A

[Applicable at test sites less than, 3,000 feet above sea level]

Arterial PCO ₂ (mm. Hg) and	Arterial PO ₂ equal to or less than (mm. Hg)
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40 or above	55

Table III - B

[Applicable at test sites 3,000 through 6,000 feet above sea level]

Arterial PCO ₂ (mm. Hg) and	Arterial PO ₂ equal to or less than (mm. Hg)
30 or below	60
31	59
32	58
33	57
34	56
35	55
36	54
37	53
38	52
39	51
40 or above	50

Table III - C

[Applicable at test sites over 6,000 feet above sea level]

Arterial PCO ₂ (mm. Hg) and	Arterial PO ₂ equal to or less than (mm. Hg)
30 or below	55
31	54
32	53
33	52
34	51
35	50
36	49
37	48
38	47
39	46
40 or above	45

11.00 NEUROLOGICAL

A. *Convulsive disorders.* In convulsive disorders, regardless of etiology degree of impairment will be determined according to type, frequency, duration, and sequelae of seizures. At least one detailed description of a typical seizure is required. Such description includes the presence or absence of aura, tongue bites, sphincter control, injuries associated with the attack, and postictal phenomena. The reporting physician should indicate the extent to which description of seizures reflects his own observations and the source of ancillary information. Testimony of persons other than the claimant is essential for description of type and frequency of seizures if professional observation is not available.

Documentation of epilepsy should include at least one electroencephalogram (EEG).

Under 11.02 and 11.03, the criteria can be applied only if the impairment persists despite the fact that the individual is following prescribed anticonvulsive treatment. Adherence to prescribed anticonvulsive therapy can ordinarily be determined from objective clinical findings in the report of the physician currently providing treatment for epilepsy. Determination of blood levels of phenytoin sodium or other anticonvulsive drugs may serve to indicate whether the prescribed medication is being taken. When seizures are occurring at the frequency stated in 11.02 or 11.03, evaluation of the severity of the impairment must include consideration of the serum drug levels. Should serum drug levels appear therapeutically inadequate, consideration should be given as to whether this is caused by individual idiosyncrasy in absorption or metabolism of the drug. Blood drug levels should be evaluated in conjunction with all the other evidence to determine the extent of compliance. When the reported blood drug levels are low, therefore, the information obtained from the treating source should include the physician's statement as to why the levels are low and the results of any relevant diagnostic studies concerning the blood levels. Where adequate seizure control is obtained only with unusually large doses, the possibility of impairment resulting from the side effects of this medication must be also assessed. Where documentation shows that use of alcohol or drugs affects adherence to prescribed therapy or may play a part in the precipitation of seizures, this must also be considered in the overall assessment of impairment level.

B. Brain tumors. The diagnosis of malignant brain tumors must be established, and the persistence of the tumor should be evaluated, under the criteria described in 13.00B and C for neoplastic disease.

In histologically malignant tumors, the pathological diagnosis alone will be the decisive criterion for severity

and expected duration (see 11.05A). For other tumors of the brain, the severity and duration of the impairment will be determined on the basis of symptoms, signs, and pertinent laboratory findings (11.05B).

C. Persistent disorganization of motor function in the form of paresis or paralysis, tremor or other involuntary movements, ataxia and sensory disturbances (any or all of which may be due to cerebral, cerebellar, brain stem, spinal cord, or peripheral nerve dysfunction) which occur singly or in various combination, frequently provides the sole or partial basis for decision in cases of neurological impairment. The assessment of impairment depends on the degree of interference with locomotion and/or interference with the use of finger, hands, and arms.

D. In conditions which are episodic in character, such as multiple sclerosis or myasthenia gravis, consideration should be given to frequency and duration of exacerbations, length of remissions, and permanent residuals.

E. Multiple sclerosis. The major criteria for evaluating impairment caused by multiple sclerosis are discussed in listing 11.09. Paragraph A provides criteria for evaluating disorganization of motor function and gives reference to 11.04B (11.04B then refers to 11.00C). Paragraph B provides references to other listings for evaluating visual or mental impairments caused by multiple sclerosis. Paragraph C provides criteria for evaluating the impairment of individuals who do not have muscle weakness of other significant disorganization of motor function at rest, but who do develop muscle weakness on activity as a result of fatigue.

Use of the criteria in 11.09C is dependent upon (1) documenting a diagnosis of multiple sclerosis, (2) obtaining a description of fatigue considered to be characteristic of multiple sclerosis and (3) obtaining evidence that the system has actually become fatigued. The evaluation of

the magnitude of the impairment must consider the degree of exercise and the severity of the resulting muscle weakness.

The criteria in 11.09C deals with motor abnormalities which occur on activity. If the disorganization of motor function is present at rest, paragraph A must be used, taking into account any further increase in muscle weakness resulting from activity.

Sensory abnormalities may occur, particularly involving central visual acuity. The decrease in visual acuity may occur after brief attempts at activity involving near vision, such as reading. This decrease in visual acuity may not persist when the specific activity is terminated, as with rest, but is predictably reproduce with resumption of the activity. The impairment of central visual acuity in these cases should be evaluated under the criteria in listing 2.02, taking into account the fact that the decrease in visual acuity will wax and wane.

Clarification of the evidence regarding central nervous system dysfunction responsible for the symptoms may require supporting technical evidence of functional impairment such as evoked response tests during exercise.

11.01 Category of Impairments, Neurological

11.02 *Epilepsy—major motor seizures, (grand mal or psychomotor), documented by EEG and by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently the once a month, in spite of at least 3 months of prescribed treatment. With:*

A. Daytime episodes (loss of consciousness and convulsive seizures) or

B. Nocturnal episodes manifesting residuals which interfere significantly with activity during the day.

11.03 *Epilepsy—Minor motor seizures (petit mal, psychomotor, or focal), documented by EEG and by*

detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once weekly in spite of at least 3 months of prescribed treatment. With alteration of awareness or loss of consciousness and transient postictal manifestation of unconventional behavior or significant interference with activity during the day.

11.04 *Central nervous system vascular accident. With one of the following more than 3 months post-vascular accident:*

A. Sensory or motor aphasia resulting in ineffective speech or communication; or

B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

11.05 *Brain tumors.*

A. Malignant gliomas (astrocytoma—grades III and IV, glioblastoma multiforme), medulloblastoma, ependymoblastoma, or primary sarcoma; or

B. Astrocytoma (grades I and II), meningioma, pituitary tumors, oligodendroglioma, ependymoma, clivus chordoma, and benign tumors. Evaluate under 11.02, 11.03, 11.04A, or B, or 12.02.

11.06 *Parkinsonian syndrome* with the following signs: Significant rigidity, brady kinesia, or tremor in two extremities, which, singly or in combination, result in sustained disturbance of gross and dexterous movements, or gait and station.

11.07 *Cerebral palsy, With:*

A. IQ of 69 or less; or

B. Abnormal behavior patterns, such as destructiveness or emotional instability; or

C. Significant interference in communication due to speech hearing, or visual defect; or

D. Disorganization of motor function as described in 11.04B.

11.08 *Spinal cord or nerve root lesions, due to any cause* with disorganization of motor function as described in 11.04B.

11.09 *multiple sclerosis*. With:

A. Disorganization of motor function as described in 11.04B; or

B. Visual or mental impairment as described under the criteria in 2.02, 2.03, 2.04, or 12.02; or

C. Significant, reproducible fatigue of motor function with substantial muscle weakness on repetitive activity, demonstrated on physical examination, resulting from neurological dysfunction in areas of the central nervous system known to be pathologically involved by the multiple sclerosis process.

11.10 *Amyotrophic lateral sclerosis*. With:

A. Significant bulbar signs; or

B. Disorganization of motor function as described in 11.04B.

11.011 *Anterior poliomyelitis*. With:

A. Persistent difficulty with swallowing or breathing; or

B. Unintelligible speech; or

C. Disorganization of motor function as described in 11.04B.

11.12 *Myasthenia gravis*. With:

A. Significant difficulty with speaking, swallowing, or breathing while on prescribed therapy; or

B. Significant motor weakness of muscles of extremities on repetitive activity against resistance while on prescribed therapy.

11.13 *Muscular dystrophy* with disorganization of motor function as described in 11.04B.

11.14 *Peripheral neuropathies*.

With disorganization of motor function as described in 11.04B, in spite of prescribed treatment.

11.15 *Tabes dorsalis*.

With:

A. Tabetic crises occurring more frequently than once monthly; or

B. Unsteady, broad-based or ataxic gait causing significant restriction of mobility substantiated by appropriate posterior column signs.

11.16 *Subacute combined cord degeneration (pernicious anemia) with disorganization of motor function as described in 11.04B or 11.15B, not significantly improved by prescribed treatment*.

11.17 *Degenerative disease not elsewhere such as Huntington's chorea, Friedreich's ataxia, and spino-cerebellar degeneration*.

With:

A. Disorganization of motor function as described in 11.04B or 11.15B; or

B. Chronic brain syndrome. Evaluate under 12.02.

11.18 *Cerebral trauma*:

Evaluate under the provisions of 11.02, 11.03, 11.04 and 12.02, as applicable.

11.19 *Syringomyelia*.

With:

A. Significant bulbar signs; or

B. Disorganization of motor function as described in 11.04B.

12.00 MENTAL DISORDERS

The mental disorder listings in 12.00 of the Listing of Impairments will only be effective for 3 years unless extended by the Secretary or revised and promulgated again. Consequently, these listings will no longer be effective on August 28, 1988.

A. Introduction: The evaluation of disability on the basis of mental disorders requires the documentation of a medically determinable impairment(s) as well as consideration of the degree of limitation such impairment(s) may impose on the individual's ability to work and whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. The listings for mental disorders are arranged in eight diagnostic categories: organic mental disorders (12.02); schizophrenic, paranoid and other psychotic disorders (12.03); affective disorders (12.04); mental retardation and autism (12.05); anxiety related disorders (12.06); somatoform disorders (12.07); personality disorders (12.08); and substance addiction disorders (12.09). Each diagnostic group, except listings 12.05 and 12.09, consists of a set of clinical findings (paragraph A criteria), one or more of which must be met, and which, if met, lead to a test of functional restrictions (paragraph B criteria), two or three of which must also be met. There are additional considerations (paragraph C criteria) in listings 12.03 and 12.06, discussed therein.

The purpose of including the criteria in paragraph A of the listings for mental disorders is to medically substantiate the presence of a mental disorder. Specific signs and symptoms under any of the listings 12.02 through 12.09 cannot be considered in isolation from the description of the mental disorder contained at the beginning of each listing category. Impairments should be analyzed or reviewed under the mental category(ies) which is supported by the individual's clinical finding.

The purpose of including the criteria in paragraphs B and C of the listings for mental disorders is to describe those functional limitations associated with mental disorders which are incompatible with the ability to work. The restrictions listed in paragraphs B and C must be the result of the mental disorder which is manifested by the

clinical findings outlined in paragraph A. The criteria included in paragraphs B and C of the listings for mental disorders have been chosen because they represent functional areas deemed essential to work. An individual who is severely limited in these areas as the result of an impairment identified in paragraph A is presumed to be unable to work.

The structure of the listing for substance addiction disorders, listing 12.09, is different from that for the other mental disorder listings. Listing 12.09 is structured as a reference listing; that is, it will only serve to indicate which of the other listed mental or physical impairments must be used to evaluate the behavioral or physical changes resulting from regular use of addictive substances.

The listings for mental disorder are so constructed that an individual meeting or equaling the criteria could no reasonably be expected to engage in gainful work activity.

Individuals who have an impairment with a level of severity which does not meet the criteria of the listings for mental disorders may or may not have the residual functional capacity (RFC) which would enable them to engage in substantial gainful work activity. The determination of mental RFC is crucial to the evaluation of an individual's capacity to engage in substantial gainful work activity when the criteria of the listings for mental disorders are not met or equaled but the impairment is nevertheless severe.

RFC may be defined as a multidimensional description of the work-related abilities which an individual retains in spite of medical impairments. RFC complements the criteria in paragraphs B and C of the listings for mental disorders by requiring consideration of an expanded list of work-related capacities which may be impaired by mental disorder when the impairment is severe but does not meet or equal a listed mental disorder. (While RFC may be applicable in most claims, the law specifies that it does not

apply to the following special claims categories: disabled title XVI children below age 18, widows, widowers and surviving divorced wives. The impairment(s) of these categories must meet or equal a listed impairment for the individual to be eligible for benefits based on disability.)

B. Need for Medical Evidence: The existence of a medically determinable impairment of the required duration must be established by medical evidence consisting of clinical signs, symptoms and/or laboratory or psychological test findings. These findings may be intermittent or persistent depending on the nature of the disorder. Clinical signs are medically demonstrable phenomena which reflect specific abnormalities of behavior, affect, thought, memory, orientation, or contact with reality. These signs are typically assessed by a psychiatrist or psychologist and/or documented by psychological tests. Symptoms are complaints presented by the individual. Signs and symptoms generally cluster together to constitute recognizable clinical syndromes (mental disorders). Both symptoms and signs which are part of any diagnosed mental disorder must be considered in evaluating severity.

C. Assessment of Severity: For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph B of the listings for mental disorders (descriptions of restrictions of activities of daily living; social functioning; concentration, persistence, or pace; and ability to tolerate increased mental demands associated with competitive work). Where "marked" is used as a standard for measuring the degree of limitation, it means more than moderate, but less than extreme. A marked limitation may arise when several activities or functions are impaired or even when only one is impaired, so long as the degree of limitation is such as to seriously interfere with the ability to function in-

dependently, appropriately and effectively. Four areas are considered.

1. *Activities of daily living* include adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for one's grooming and hygiene, using telephones and directories, using a post office, etc. In the context of the individual's overall situation, the quality of these activities is judged by their independence, appropriateness and effectiveness. It is necessary to define the extent to which the individual is capable of initiating and participating in activities independent of supervision or direction.

"Marked" is not the number of activities which are restricted but the overall degree of restriction or combination of restrictions which must be judged. For example, a person who is able to cook and clean might still have marked restrictions of daily activities if the person were too fearful to leave the immediate environment of home and neighborhood, hampering the person's ability to obtain treatment or to travel away from the immediate living environment.

2. *Social functioning* refers to an individual's capacity to interact appropriately and communicate effectively with other individuals. Social functioning includes the ability to get along with others, e.g., family members, friends, neighbors, grocery clerks, landlords, bus drivers, etc. Impaired social functioning may be demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation, etc. Strength in social functioning may be documented by an individual's ability to initiate social contacts with others, communicate clearly with others, interact and actively participate in group activities, etc. Cooperative behaviors, consideration for others, awareness of others'

feelings, and social maturity also need to be considered. Social functioning in work situations may involve interactions with the public, responding appropriately to persons in authority, e.g., supervisors, or cooperative behaviors involving coworkers.

"Marked" is not the number of areas in which social functioning is impaired, but the overall degree of interference in a particular area or combination of areas of functioning. For example, a person who is highly antagonistic, uncooperative or hostile but is tolerated by local storekeepers may nevertheless have marked restrictions in social functioning because that behavior is not acceptable in other social contexts.

3. *Concentration, persistence and pace* refer to the ability to sustain focused attention sufficiently long to permit the timely completion of tasks commonly found in work settings. In activities of daily living, concentration may be reflected in terms of ability to complete tasks in everyday household routines. Deficiencies in concentration, persistence and pace are best observed in work and work-like settings. Major impairment in this area can often be assessed through direct psychiatric examination and/or psychological testing, although mental status examination or psychological test data alone should not be used to accurately describe concentration and sustained ability to adequately perform work-like tasks. On mental status examinations, concentration is assessed by tasks such as having the individual subtract serial sevens from 100. In psychological tests of intelligence or memory, concentration is assessed through tasks requiring short-term memory or through tasks that must be completed within established time limits. In work evaluations, concentration, persistence, and pace are assessed through such tasks as filing index cards, locating telephone numbers, or disassembling and reassembling objects. Strengths and weak-

nesses in areas of concentration can be discussed in terms of frequency of errors, time it takes to complete the task, and extent to which assistance is required to complete the task.

4. *Deterioration or decompensation in work or work-like settings* refers to repeated failure to adapt to stressful circumstances which cause the individual either to withdraw from that situation or to experience exacerbation of signs and symptoms (i.e., decompensation) with an accompanying difficulty in maintaining activities of daily living, social relationships, and/or maintaining concentration, persistence, or pace (i.e., deterioration which may include deterioration of adaptive behaviors). Stresses common to the work environment include decisions, attendance, schedules, completing tasks, interactions with supervisors, interactions with peers, etc.

D. *Documentation*: The presence of a mental disorder should be documented primarily on the basis of reports from individual providers, such as psychiatrists and psychologists, and facilities such as hospitals and clinics. Adequate descriptions of functional limitations must be obtained from these or other sources which may include programs and facilities where the individual has been observed over a considerable period of time.

Information from both medical and nonmedical sources may be used to obtain detailed descriptions of the individual's activities of daily living; social functioning; concentration, persistence and pace; or ability to tolerate increased mental demands (stress). This information can be provided by programs such as community mental health centers, day care centers, sheltered workshops, etc. It can also be provided by others, including family members, who have knowledge of the individual's functioning. In some cases descriptions of activities of daily living or social functioning given by individuals or treating sources

may be insufficiently detailed and/or may be in conflict with the clinical picture otherwise observed or described in the examinations or reports. It is necessary to resolve any inconsistencies or gaps that may exist in order to obtain a proper understanding of the individual's functional restrictions.

An individual's level of functioning may vary considerably over time. The level of functioning at a specific time may seem relatively adequate or, conversely, rather poor. Proper evaluation of the impairment must take any variations in level of functioning into account in arriving at a determination of impairment severity over time. Thus, it is vital to obtain evidence from relevant sources over a sufficiently long period prior to the date of adjudication in order to establish the individual's impairment severity. This evidence should include treatment notes, hospital discharge summaries, and work evaluation or rehabilitation progress notes if these are available.

Some individuals may have attempted to work or may actually have worked during the period of time pertinent to the determination of disability. This may have been an independent attempt at work, or it may have been in conjunction with a community mental health or other sheltered program which may have been of either short or long duration. Information concerning the individual's behavior during any attempt to work and the circumstances surrounding termination of the work effort are particularly useful in determining the individual's ability or inability to function in a work setting.

The results of well-standardized psychological tests such as the Weschsler Adult Intelligence Scale (WAIS), the Minnesota Multiphasic Personality Inventory (MMPI), the Rorschach, and the Thematic Apperception Test (TAT), may be useful in establishing the existence of a mental disorder. For example, the WAIS is useful in estab-

lishing the existence of a mental disorder. For example, the WAIS is useful in establishing mental retardation, and the MMPI, Rorschach, and TAT may provide data supporting several other diagnoses. Broad-based neuropsychological assessments using, for example, the Halstead-Reitan or the Luria-Nebraska batteries may be useful in determining brain function deficiencies, particularly in cases involving subtle findings such as may be seen in traumatic brain injury. In addition, the process of taking a standardized test requires concentration, persistence and pace; performance on such tests may provide useful data. Test results should, therefore, include both the objective data and a narrative description of clinical findings. Narrative reports of intellectual assessment should include a discussion of whether or not obtained IQ scores are considered valid and consistent with the individual's developmental history and degree of functional restriction.

In cases involving impaired intellectual functioning, a standardized intelligence test, e.g., the WAIS, should be administered and interpreted by a psychologist or psychiatrist qualified by training and experience to perform such an evaluation. In special circumstances, nonverbal measures, such as the Raven Progressive Matrices, the Leiter international scale, or the Arthur adaptation of the Leiter may be substituted.

Identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. In this connection, it must be noted that on the WAIS, for example, IQs of 69 and below are characteristic of approximately the lowest 2 percent of the general population. In instances where other tests are administered, it would be necessary to convert the IQ to the corresponding percentile rank in the general population in order to determine the actual degree of impairment reflected by those IQ scores.

In cases where more than one IQ is customarily derived from the test administered, i.e., where verbal, performance, and full-scale IQs are provided as on the WAIS, the lowest of these is used in conjunction with listing 12.05.

In cases where the nature of the individual's intellectual impairment is such that standard intelligence tests, as described above, are precluded, medical reports specifically describing the level of intellectual, social, and physical function should be obtained. Actual observations by Social Security Administration or State agency personnel, reports from educational institutions and information furnished by public welfare agencies or other reliable objective sources should be considered as additional evidence.

E. *Chronic Mental Impairments:* Particular problems are often involved in evaluating mental impairments in individuals who have long histories of repeated hospitalizations or prolonged outpatient care with supportive therapy and medication. Individuals with chronic psychotic disorders commonly have their lives structured in such a way as to minimize stress and reduce their signs and symptoms. Such individuals may be much more impaired for work than their signs and symptoms would indicate. The results of a single examination may not adequately describe these individuals' sustained ability to function. It is, therefore, vital to review all pertinent information relative to the individual's condition, especially at times of increased stress. It is mandatory to attempt to obtain adequate descriptive information from all sources which have treated the individual either currently or in the time period relevant to the decision.

F. *Effects of Structured Settings:* Particularly in cases involving chronic mental disorders, overt symptomatology may be controlled or attenuated by psychosocial factors such as placement in a hospital, board and care facility, or

other environment that provides similar structure. Highly structured and supportive settings may greatly reduce the mental demands placed on an individual. With lowered mental demands, overt signs and symptoms of the underlying mental disorder maybe minimized. At the same time, however, the individual's ability to function outside of such a structured and/or supportive setting may not have changed. An evaluation of individuals whose symptomatology is controlled or attenuated by psychosocial factors must consider the ability of the individual to function outside of such highly structured settings. (For these reasons the paragraph C criteria were added Listings 12.03 and 12.06.)

G. *Effects of Medication:* Attention must be given to the effect of medication on the individual's signs, symptoms and ability to function. While psychotropic medications may control certain primary manifestations of a mental disorder, e.g., hallucinations, such treatment may or may not affect the functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the psychotropic medications, particular attention must be focused on the functional restrictions which may persist. These functional restrictions are also to be used as the measure of impairment severity. (See the paragraph C criteria in Listings 12.03 and 12.06.)

Neuroleptics, the medicines used in the treatment of some mental illnesses, may cause drowsiness, blunted affect, or other side effects involving other body systems. Such side effects must be considered in evaluating overall impairment severity. Where adverse effects of medications contribute to the impairment severity and the impairment does not meet or equal the listings but is nonetheless severe, such adverse effects must be considered in the assessment of the mental residual functional capacity.

H. *Effect of Treatment*: it must be remembered that with adequate treatment some individuals suffering with chronic mental disorders not only have their symptoms and signs ameliorated but also return to a level of function close to that of their premorbid status. Our discussion here in 12.00H has been designed to reflect the fact that present day treatment of a mentally impaired individual may or may not assist in the achievement of an adequate level of adaptation required in the work place. (See the paragraph C criteria in Listings 12.03 and 12.06.)

1. *Technique for Reviewing the Evidence in Mental Disorders Claims to Determine Level of Impairment Severity*: A special technique has been developed to ensure that all evidence needed for the evaluation of impairment severity in claims involving mental impairment is obtained, considered and properly evaluated. This technique, which is used in connection with the sequential evaluation process, is explained in § 404.1520a and § 416.920a.

12.01 Category of Impairments-Mental

12.02 *Organic Mental Disorders*: Psychological or behavioral abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Demonstration of a loss of specific cognitive abilities or affective changes and the medically documented persistence of at least one of the following:

1. Disorientation to time and place; or
2. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (in-

ability to remember information that was known sometime in the past); or

3. Perceptual or thinking disturbances (e.g., hallucinations, delusions); or

4. Change in personality; or

5. Disturbance in mood; or

6. Emotional lability (e.g., explosive temper outbursts, sudden crying, etc.) and impairment in impulse control; or

7. Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on neuropsychological testing, e.g., the Luria-Nebraska, Halstead-Reitan, etc.;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.03 *Schizophrenic, Paranoid and Other Psychotic Disorders*: Characterized by the onset of psychotic features with deterioration from a previous level of functioning.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or
2. Catatonic or other grossly disorganized behavior;

or

3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:

- a. Blunt affect; or
- b. Flat affect; or
- c. Inappropriate affect;

or

4. Emotional withdrawal and/or isolation; AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors);

OR

C. Medically documented history of one or more episodes of acute symptoms, signs and functional limitations which at the time met the requirements in A and B of this listing, although these symptoms or signs are currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of deterioration or decompensation in situations which cause the individual to withdraw from that situation or to experience exacerbation of signs

or symptoms (which may include deterioration of adaptive behaviors); or

2. Documented current history of two or more years of inability to function outside of a highly supportive living situation.

12.04 *Affective Disorders*: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:

- a. Anhedonia or pervasive loss of interest in almost all activities; or
- b. Appetite disturbance with change in weight; or
- c. Sleep disturbance; or
- d. Psychomotor agitation or retardation; or
- e. Decreased energy; or
- f. Feelings of guilt or worthlessness; or
- g. Difficulty concentrating or thinking; or
- h. Thoughts of suicide; or
- i. Hallucinations, delusions or paranoid thinking; or

2. Manic syndrome characterized by at least three of the following:

- a. Hyperactivity; or
- b. Pressure of speech; or
- c. Flight of ideas; or
- d. Inflated self-esteem; or
- e. Decreased need for sleep; or
- f. Easy distractability; or

g. Involvement in activities that have a high probability of painful consequences which are not recognized;
or

h. Hallucinations, delusions or paranoid thinking;
or

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.05 Mental Retardation and Autism: Mental retardation refers to a significantly subaverage general intellectual functioning with deficits in adaptive behavior initially manifested during the developmental period (before age 22). (Note: The scores specified below refer to those obtained on the WAIS, and are used only for reference purposes. Scores obtained on other standardized and individually administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning.) Autism is a pervasive developmental disorder characterized by social and significant communication deficits originating in the developmental period.

The required level of severity for this disorder is met when the requirements in A, B, C, or D are satisfied.

A. Mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating, dressing, or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded;

OR

B. A valid verbal, performance, or full scale IQ of 59 or less;

OR

C. A valid verbal, performance, or full scale IQ of 60 to 69 inclusive and a physical or other mental impairment imposing additional and significant work-related limitation of function;

OR

D. A valid verbal, performance, or full scale IQ of 60 to 69 inclusive or in the case of autism gross deficits of social and communicative skills with two of the following;

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.06 Anxiety Related Disorders: In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation

in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in both A and C are satisfied.

A. Medically documented findings of at least one of the following:

1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:

- a. Motor tension; or
- b. Autonomic hyperactivity; or
- c. Apprehensive expectation; or
- d. Vigilance and scanning;

or

2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or

4. Recurrent obsessions or compulsions which are a source of marked distress; or

5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the indi-

vidual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors);

OR

C. Resulting in complete inability to function independently outside the area of one's home.

12.07 *Somatoform Disorders*: Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented by evidence of one of the following:

1. A history of multiple physical symptoms of several years duration, beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly; or

2. Persistent nonorganic disturbance of one of the following:

- a. Vision; or
- b. Speech; or
- c. Hearing; or
- d. Use of a limb; or
- e. Movement and its control (e.g., coordination disturbance, psychogenic seizures, akinesia, dyskinesia; or
- f. Sensation (e.g., diminished or heightened).

3. Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury;

AND

B. Resulting in three of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behavior).

12.08 Personality Disorders: A personality disorder exists when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress. Characteristic features are typical of the individual's long-term functioning and are not limited to discrete episodes of illness.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Deeply ingrained, maladaptive patterns of behavior associated with one of the following:

1. Seclusiveness or autistic thinking; or
2. Pathologically inappropriate suspiciousness or hostility; or
3. Oddities of thought, perception, speech and behavior; or
4. Persistent disturbances of mood or affect; or
5. Pathological dependence, passivity, or aggressivity; or

6. Intense and unstable interpersonal relationships and impulsive and damaging behavior;

AND

- B. Resulting in three of the following:
1. Marked restriction of activities of daily living; or
 2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.09 Substance Addiction Disorders: Behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system.

The required level of severity for these disorders is met when the requirements in any of the following (A through I) are satisfied.

- A. Organic mental disorders. Evaluate under 12.02.
- B. Depressive syndrome. Evaluate under 12.04.
- C. Anxiety disorders. Evaluate under 12.06.
- D. Personality disorders. Evaluate under 12.08.
- E. Peripheral neuropathies. Evaluate under 11.14.
- F. Liver damage. Evaluate under 5.05.
- G. Gastritis. Evaluate under 5.04.
- H. Pancreatitis. Evaluate under 5.08.
- I. Seizures. Evaluate under 11.02 or 11.03.

13.00 NEOPLASTIC DISEASES, MALIGNANT

A. *Introduction:* The determination of the level of impairment resulting from malignant tumors is made from a consideration of the site of the lesion, the histogenesis of the tumor, the extent of involvement, the apparent adequacy and response to therapy (surgery, irradiation, hormones, chemotherapy, etc.), and the magnitude of the post therapeutic residuals.

B. *Documentation:* The diagnosis of malignant tumors should be established on the basis of symptoms,

signs, and laboratory findings. The site of the primary, recurrent, and metastatic lesion must be specified in all cases of malignant neoplastic diseases. If an operative procedure has been performed, the evidence should include a copy of the operative note and the report of the gross and microscopic examination of the surgical specimen. If these documents are not obtainable, then the summary of hospitalization or a report from the treating physician must include details of the findings at surgery and the results of the pathologist's gross and microscopic examination of the tissues.

For those cases in which a disabling impairment was not established when therapy was begun but progression of the disease is likely, current medical evidence should include a report of a recent examination directed especially at local or regional recurrence, soft part or skeletal metastases, and significant posttherapeutic residuals.

C. *Evaluation.* Usually, when the malignant tumor consists of a local lesion with metastases to the regional lymph nodes which apparently has been completely excised, imminent recurrence or metastases is not anticipated. A number of exceptions are noted in the specific Listings. For adjudicative purposes, "distant metastases" or "metastases beyond the regional lymph nodes" refers to metastasis beyond the lines of the usual radical en bloc resection.

Local or regional recurrence after radical surgery or pathological evidence of incomplete excision by radical surgery is to be equated with unresectable lesions (except for carcinoma of the breast, 13.09C) and, for the purposes of our program, may be evaluated as "inoperable."

Local or regional recurrence after incomplete excision of a localized and still completely resectable tumor is not to be equated with recurrence after radical surgery. In the evaluation of lymphomas, the tissue type and site of in-

volvement are not necessarily indicators of the degree of impairment.

When a malignant tumor has metastasized beyond the regional lymph nodes, the impairment will usually be found to meet the requirements of a specific listing. Exceptions are hormone-dependent tumors, isotope-sensitive metastases, and metastases from seminoma of the testicles which are controlled by definitive therapy.

When the original tumor and any metastases have apparently disappeared and have not been evident for 3 or more years, the impairment does not meet the criteria under this body system.

D. *Effects of therapy.* Significant posttherapeutic residuals, not specifically included in the category of impairments for malignant neoplasms, should be evaluated according to the affected body system.

Where the impairment is not listed in the Listing of Impairments and is not medically equivalent to a listed impairment, the impact of any residual impairment including that caused by therapy must be considered. The therapeutic regimen and consequent adverse response to therapy may vary widely; therefore, each case must be considered on an individual basis. It is essential to obtain a specific description of the therapeutic regimen, including the drugs given, dosage, frequency of drug administration, and plans for continued drug administration. It is necessary to obtain a description of the complications or any other adverse response to therapy such as nausea, vomiting, diarrhea, weakness, dermatologic disorders, or reactive mental disorders. Since the severity of the adverse effects of anticancer chemotherapy may change during the period of drug administration, the decision regarding the impact of drug therapy should be based on a sufficient period of therapy to permit proper consideration.

E. *Onset.* To establish onset of disability prior to the time a malignancy is first demonstrated to be inoperable or beyond control by other modes of therapy (and prior evidence is nonexistent) requires medical judgment based on medically reported symptoms, the type of the specific malignancy, its location, and extent of involvement when first demonstrated.

13.01 Category of Impairments, Neoplastic Diseases—Malignant

13.02 *Head and neck* (except salivary glands—13.07, thyroid gland—13.08, and mandible, maxilla, orbit, or temporal fossa—13.11):

- A. Inoperable; or
- B. Not controlled by prescribed therapy; or
- C. Recurrent after radical surgery or irradiation; or
- D. With distant metastases; or
- E. Epidermoid carcinoma occurring in the pyriform sinus or posterior third of the tongue.

13.03 *Sarcoma of skin:*

- A. Angiosarcoma with metastases to regional lymph nodes or beyond; or
- B. Mycosis fungoides with metastases to regional lymph nodes, or with visceral involvement.

13.04 *Sarcoma of soft parts:* Not controlled by prescribed therapy.

13.05 *Malignant melanoma:*

- A. Recurrent after wide excision; or
- B. With metastases to adjacent skin (satellite lesions) or elsewhere.

13.06 *Lymph nodes:*

A. Hodgkin's disease or non-Hodgkin's lymphoma with progressive disease not controlled by prescribed therapy; or

B. Metastatic carcinoma in a lymph node (except for epidermoid carcinoma in a lymph node in the neck) where

the primary site is not determined after adequate search; or

C. Epidermoid carcinoma in a lymph node in the neck not responding to prescribed therapy.

13.07 *Salivary glands*—carcinoma or sarcoma with metastases beyond the regional lymph nodes.

13.08 *Thyroid gland*—carcinoma with metastases beyond the regional lymph nodes, not controlled by prescribed therapy.

13.09 *Breast:*

- A. Inoperable carcinoma; or
- B. Inflammatory carcinoma; or
- C. Recurrent carcinoma, except local recurrence controlled by prescribed therapy; or
- D. Distant metastases from breast carcinoma (bilateral breast carcinoma, synchronous or metachronous is usually primary in each breast); or
- E. Sarcoma with metastases anywhere.

13.10 *Skeletal system* (exclusive of the jaw):

- A. Malignant primary tumors with evidence of metastases and not controlled by prescribed therapy; or
- B. Metastatic carcinoma to bone where the primary site is not determined after adequate search.

13.11 *Mandible, maxilla, orbit, or temporal fossa:*

- A. Sarcoma of any type with metastases; or
- B. Carcinoma of the antrum with extension into the orbit or ethmoid or sphenoid sinus, or with regional or distant metastases; or
- C. Orbital tumors with intracranial extension; or
- D. Tumors of the temporal fossa with perforation of skull and meningeal involvement; or
- E. Adamantinoma with orbital or intracranial infiltration; or
- F. Tumors of Rathke's pouch with infiltration of the base of the skull or metastases.

13.12 *Brain or spinal cord:*

- A. Metastatic carcinoma to brain to spinal cord.
- B. Evaluate other tumors under the criteria described in 11.05 and 11.08.

13.13 *Lungs.*

- A. Unresectable or with incomplete excision; or
- B. Recurrence or metastases after resection; or
- C. Oat cell (small cell) carcinoma; or
- D. Squamous cell carcinoma, with metastases beyond the hilar lymph nodes; or
- E. Other histologic types of carcinoma, including undifferentiated and mixed-cell types (but excluding oat cell carcinoma, 13.13C, and squamous cell carcinoma, 13.13D), with metastases to the hilar lymph nodes.

13.14 *Pleura or mediastinum:*

- A. Malignant mesothelioma of pleura; or
- B. Malignant tumors, metastatic to pleura; or
- C. Malignant primary tumor of the mediastinum not controlled by prescribed therapy.

13.15 *Abdomen:*

- A. Generalized carcinomatosis; or
- B. Retroperitoneal cellular sarcoma not controlled by prescribed therapy; or
- C. Ascites with demonstrated malignant cells.

13.16 *Esophagus or stomach:*

- A. Carcinoma or sarcoma of the esophagus; or
- B. Carcinoma of the stomach with metastases to the regional lymph nodes or extension to surrounding structure; or
- C. Sarcoma of stomach not controlled by prescribed therapy; or
- D. Inoperable carcinoma; or
- E. Recurrence or metastases after resection.

13.17 *Small intestine:*

- A. Carcinoma, sarcoma, or carcinoid tumor with metastases beyond the regional lymph nodes; or
- B. Recurrence of carcinoma, sarcoma, or carcinoid tumor after resection; or
- C. Sarcoma, not controlled by prescribed therapy.

13.18 *Large intestine (from ileocecal valve to and including anal canal)—carcinoma or sarcoma.*

- A. Unresectable; or
- B. Metastases beyond the regional lymph nodes; or
- C. Recurrence or metastases after resection.

13.19 *Liver or gallbladder:*

- A. Primary or metastatic malignant tumors of the liver; or
- B. Carcinoma of the gallbladder; or
- C. Carcinoma of the bile ducts.

13.20 *Pancreas:*

- A. Carcinoma except islet cell carcinoma; or
- B. Islet cell carcinoma which is unresectable and physiologically active.

13.21 *Kidneys, adrenal glands, or ureters—carcinoma:*

- A. Unresectable; or
- B. With hematogenous spread to distant sites; or
- C. With metastases to regional lymph nodes.

13.22 *Urinary bladder—carcinoma. With:*

- A. Infiltration beyond the bladder wall; or
- B. Metastases to regional lymph nodes; or
- C. Unresectable; or
- D. Recurrence after total cystectomy; or
- E. Evaluate renal impairment after total cystectomy under the criteria in 6.02.

13.23 *Prostate gland—carcinoma not controlled by prescribed therapy.*13.24 *Testicles:*

- A. Choriocarcinoma; or

B. Other malignant primary tumors with progressive disease not controlled by prescribed therapy.

13.25 *Uterus*—carcinoma or sarcoma (corpus or cervix).

A. Inoperable and not controlled by prescribed therapy; or

B. Recurrent after total hysterectomy; or

C. Total pelvic exenteration

13.26 *Ovaries*—all malignant, primary or recurrent tumors. With:

A. Ascites with demonstrated malignant cells; or

B. Unresectable infiltration; or

C. Unresectable metastases to omentum or elsewhere in the peritoneal cavity; or

D. Distant metastases.

13.27 *Leukemia*: Evaluate under the criteria of 7.00ff. Hemic and Lymphatic System [sic].

13.28 *Uterine (Fallopian) tubes*—carcinoma or sarcoma:

A. Unresectable, or

B. Metastases to regional lymph nodes.

13.29 *Penis*—carcinoma with metastases to regional lymph nodes.

13.30 *Vulva*—carcinoma, with distant metastases.

Part B

Medical criteria for the evaluation of impairments of children under age 18 (where criteria in Part A do not give appropriate consideration to the particular disease process in childhood).

Sec.

100.00 Growth Impairment.

101.00 Musculoskeletal System.

102.00 Special Senses and Speech.

103.00 Respiratory System.

104.00 Cardiovascular System.

105.00 Digestive System.

106.00 Genito-Urinary System.

107.00 Hemic and Lymphatic System.

108.00 [Reserved]

109.00 Endocrine System.

110.00 Multiple Body Systems.

111.00 Neurological.

112.00 Mental and Emotional Disorders.

113.00 Neoplastic Diseases, Malignant.

100.00 GROWTH IMPAIRMENT

A. *Impairment of growth* may be disabling in itself or it may be an indicator of the severity of the impairment due to a specific disease process.

Determinations of growth impairment should be based upon the comparison of current height with at least three previous determinations, including length at birth, if available. Heights (or lengths) should be plotted on a standard growth chart, such as derived from the National Center for Health Statistics: NCHS Growth Charts. Height should be measured without shoes. Body weight corresponding to the ages represented by the heights should be furnished. The adult heights of the child's natural parents and the heights and ages of siblings should also be furnished. This will provide a basis upon which to identify those children whose short stature represents a familial characteristic rather than a result of disease. This is particularly true for adjudication under 100.02B.

B. *Bone age determinations* should include a full descriptive report of roentgenograms specifically obtained to determine bone age and must cite the standardization method used. Where roentgenograms must be obtained

currently as a basis for adjudication under 100.03, views of the left hand and wrist should be ordered. In addition, roentgenograms of the knee and ankle should be obtained when cessation of growth is being evaluated in an older child at, or past, puberty.

C. The criteria in this section are applicable until closure of the major epiphyses. The cessation of significant increase in height at that point would prevent the application of these criteria.

100.01 Category of Impairments, Growth

100.02 *Growth impairment*, considered to be related to an additional specific medically determinable impairment, and one of the following:

A. Fall of greater than 15 percentiles in height which is sustained; or

B. Fall to, or persistence of, height below the third percentile.

100.03 *Growth impairment*, not identified as being related to an additional, specific medically determinable impairment. With:

A. Fall of greater than 25 percentiles in height which is sustained; and

B. Bone age greater than two standard deviations (2 SD) below the mean for chronological age (see 100.00B).

101.00 MUSCULOSKELETAL SYSTEM

A. *Rheumatoid arthritis*. Documentation of the diagnosis of juvenile rheumatoid arthritis should be made according to an established protocol, such as that published by the Arthritis Foundation, *Bulletin on the Rheumatic Diseases*. Vol. 23, 1972-1973 Series, p 712. Inflammatory signs include persistent pain, tenderness, erythema, swelling, and increased local temperature of a joint.

B. *The measurements of joint motion* are based on the technique for measurements described in the "Joint Method of Measuring and Recording." [sic] published by the American Academy of Orthopedic Surgeons in 1965, or "The Extremities and Back" in *Guides to the Evaluation of Permanent Impairment*, Chicago, American Medical Association, 1971, Chapter 1, pp. 1-48.

C. *Degenerative arthritis* may be the end stage of many skeletal diseases and conditions, such as traumatic arthritis, congenital dislocation of the hip, aseptic necrosis of the hip, slipped capital femoral epiphyses, skeletal dysplasias, etc.

101.02 Category of Impairments, Musculoskeletal

101.02 *Juvenile rheumatoid arthritis*. With:

A. Persistence or recurrence of joint inflammation despite three months of medical treatment and one of the following:

1. Limitation of motion of two major joints of 50 percent or greater; or

2. Fixed deformity of two major weight-bearing joints of 30 degrees or more; or

3. Radiographic changes of joint narrowing, erosion, or subluxation; or

4. Persistent or recurrent systemic involvement such as iridocyclitis or pericarditis; or

B. Steroid dependence.

101.03 *Deficit of musculoskeletal function* due to deformity or musculoskeletal disease and one of the following:

A. Walking is markedly reduced in speed or distance despite orthotic or prosthetic devices; or

B. Ambulation is possible only with obligatory bilateral upper limb assistance (e.g., with walker, crutches); or

C. Inability to perform age-related personal self-care activities involving feeding, dressing, and personal hygiene.

101.05 *Disorders of the spine.*

A. Fracture of vertebra with cord involvement (substantiated by appropriate sensory and motor loss); or

B. Scoliosis (congenital idiopathic or neuromyopathic). With:

1. Major spinal curve measure 60 degrees or greater; or

2. Spinal fusion of six or more levels. Consider under a disability for one year from the time of surgery; thereafter evaluate the residual impairment; or

3. FEV (vital capacity) of 50 percent or less of predicted normal values for the individual's measured (actual) height; or

C. Kyphosis or lordosis measuring 90 degrees or greater.

101.08 *Chronic osteomyelitis* with persistence or recurrence of inflammatory signs or drainage for at least 6 months despite prescribed therapy and consistent radiographic findings.

102.00 SPECIAL SENSES AND SPEECH

A. *Visual impairments in children.* Impairment of central visual acuity should be determined with use of the standard Snellen test chart. Where this cannot be used, as in very young children, a complete description should be provided of the findings using other appropriate methods of examination, including a description of the techniques used for determining the central visual acuity for distance.

The accommodative reflex is generally not present in children under 6 months of age. In premature infants, it may not be present until 6 months plus the number of months the child is premature. Therefore absence of accommodative reflex will be considered as indicating a visual impairment only in children above this age (6 months).

Documentation of a visual disorder must include description of the ocular pathology.

B. *Hearing impairments in children.* The criteria for hearing impairments in children take into account that a lesser impairment in hearing which occurs at an early age may result in a severe speech and language disorder.

Improvement by a hearing aid, as predicted by the testing procedure, must be demonstrated to be feasible in that child, since younger children may be unable to use a hearing aid effectively.

The type of audiometric testing performed must be described and a copy of the results must be included. The pure tone air conduction hearing levels in 102.08 are based on American National Standard Institute Specifications for Audiometers, S3.6-1969 (ANSI-1969). The report should indicate the specifications used to calibrate the audiometer.

The finding of a severe impairment will be based on the average hearing levels at 500, 1000, 2000, and 3000 Hertz (Hz) in the better ear, and on speech discrimination, as specified in § 102.08.

102.01 Category of Impairments, Special Sense Organs

102.02 *Impairments of central visual acuity.*

A. Remaining vision in the better eye after best correction is 20/200 or less; or

B. For children below 3 years of age at time of adjudication:

1. Absence of accommodative reflex (see 102.00A for exclusion of children under 6 months of age); or

2. Retrolental fibroplasia with macular scarring or neovascularization; or

3. Bilateral congenital cataracts with visualization of retinal red reflex only or when associated with other ocular pathology.

102.08 *Hearing impairments.*

A. For children below 5 years of age at time of adjudication, inability to hear air conduction thresholds at an average of 40 decibels (db) hearing level or greater in the better ear; or

B. For children 5 years of age and above at time of adjudication:

1. Inability to hear air conduction thresholds at an average of 70 decibels (db) or greater in the better ear; or

2. Speech discrimination scores at 40 percent or less in the better ear; or

3. Inability to hear air conduction thresholds at an average of 40 decibels (db) or greater in the better ear, and a speech and language disorder which significantly affects the clarity and content of the speech and is attributable to the hearing impairment.

103.00 RESPIRATORY SYSTEM

A. *Documentation of pulmonary insufficiency.* The reports of spirometric studies for evaluation under Table I must be expressed in liters (BTPS). The reported FEV₁ should represent the largest of at least three satisfactory attempts. The appropriately labeled spirometric tracing of three FEV maneuvers must be submitted with the report, showing distance per second on the abscissa and distance per liter on the ordinate. The unit distance for volume on the tracing should be at least 15 mm. per liter and the paper speed at least 20 mm. per second. The height of the individual without shoes must be recorded.

The ventilatory function studies should not be performed during or soon after an acute episode or exacerbation of a respiratory illness. In the presence of acute bronchospasm, or where the FEV₁ is less than that stated in Table I, the studies should be repeated after the admini-

stration of a nebulized bronchodilator. If a bronchodilator was not used in such instances, the reason should be stated in the report.

A statement should be made as to the child's ability to understand directions and to cooperate in performance of the test, and should include an evaluation of the child's effort. When tests cannot be performed or completed, the reason (such as a child's young age) should be stated in the report.

B. *Cystic fibrosis.* This section discusses only the pulmonary manifestations of cystic fibrosis. Other manifestations, complications, or associated disease must be evaluated under the appropriate section.

The diagnosis of cystic fibrosis will be based upon appropriate history, physical examination, and pertinent laboratory findings. Confirmation based upon elevated concentration of sodium or chloride in the sweat should be included, with indication of the technique used for collection and analysis.

103.01 *Category of Impairments, Respiratory.*

103.03 *Bronchial asthma.* With evidence of progression of the disease despite therapy and documented by one of the following:

A. Recent, recurrent intense asthmatic attacks requiring parenteral medication; or

B. Persistent prolonged expiration with wheezing between acute attacks and radiographic findings of peribronchial disease.

103.13 *Pulmonary manifestations of cystic fibrosis.* With:

A. FEV₁ equal to or less than the values specified in Table I (see § 103.00A for requirements of ventilatory function testing); or

B. For children where ventilatory function testing cannot be performed:

1. History of dyspnea on mild exertion or chronic frequent productive cough; and
2. Persistent or recurrent abnormal breath sounds, bilateral rales or rhonchi; and
3. Radiographic findings of extensive disease with hyperaeration and bilateral peribronchial infiltration.

Table I

Height (in centimeters)	FEV ₁ equal to or less than (L, BTPS)
110 or less	0.6
120	0.7
130	0.9
140	1.1
150	1.3
160	1.5
170 or more	1.6

104.00 CARDIOVASCULAR SYSTEM

A. *General.* Evaluation should be based upon history, physical findings, and appropriate laboratory data. Reported abnormalities should be consistent with the pathologic diagnosis. The actual electrocardiographic tracing, or an adequate marked photocopy, must be included. Reports of other pertinent studies necessary to substantiate the diagnosis or describe the severity of the impairment must also be included:

B. *Evaluation of cardiovascular impairment in children* requires two steps:

1. The delineation of a specific cardiovascular disturbance, either congenital or or [sic] acquired. This may include arterial or venous disease, rhythm disturbance, or

disease involving the valves, septa, myocardium or pericardium; and

2. Documentation of the severity of the impairment, with medically determinable and consistent cardiovascular signs, symptoms, and laboratory data. In cases where impairment characteristics are questionably secondary to the cardiovascular disturbance, additional documentation of the severity of the impairment (e.g., catheterization data, if performed) will be necessary.

C. *Chest roentgenogram* (6 ft. PA film) will be considered indicative of cardiomegaly if:

1. The cardiothoracic ratio is over 60 percent at age one year or less, or 55 percent at more than one year of age; or
2. The cardiac size is increased over 15 percent from any prior chest roentgenograms; or
3. Specific chamber or vessel enlargement is documented in accordance with established criteria.

D. *Tables I, II and III* below are designed for case adjudication and not for diagnostic purposes. The adult criteria may be useful for older children and should be used when applicable.

E. *Rheumatic fever*, as used in this section assumes diagnosis made according to the revised Jones Criteria.

104.01 Category of Impairments, Cardiovascular

104.02 *Chronic congestive failure.* With two or more of the following signs:

- A. Tachycardia (see Table I).
- B. Tachypnea (see Table II).
- C. Cardiomegaly on chest roentgenogram (see 104.00C).
- D. Hepatomegaly (more than 2 cm. below the right costal margin in the right midclavicular line).
- E. Evidence of pulmonary edema, such as rales or orthopnea.

F. Dependent edema.

G. Exercise intolerance manifested as labored respiration on mild exertion (e.g., in an infant, feeding).

TABLE I—TACHYCARDIA AT REST

Age	Apical Heart (beats per minute)
Under 1 yr	150
1 through 3 yrs	130
4 through 9 yrs	120
10 through 15 yrs	110
Over 15 yr	100

TABLE II—TACHYPNEA AT REST

Age	Respiratory rate over (per minute)
Under 1 yr	40
1 through 5 yrs	35
6 through 9 yrs	30
Over 9 yrs	25

104.03 *Hypertensive cardiovascular disease.* With persistently elevated blood pressure for age (see Table III) and one of the following:

A. Impaired renal function as described under the criteria in 106.02; or

B. Cerebrovascular damage as described under the criteria in 111.06; or

C. Congestive heart failure as described under the criteria in 104.02.

TABLE III—ELEVATED BLOOD PRESSURE

Age	S (over) mm.	Diastolic (over) in mm.
Under 6 mo	95	60
6 mo. to 1 yr	110	70
1 through 8 yrs	115	80
9 through 11 yrs	120	80
12 through 15 yrs	130	80
Over 15 yrs.	140	80

104.04 *Cyanotic congenital heart disease.*

With one of the following:

A. Surgery is limited to palliative measures; or

B. Characteristic squatting, hemoptysis, syncope, or hypercyanotic spells; or

C. Chronic hematocrit of 55 percent of greater or arterial O₂ saturation of less than 90 percent at rest, or arterial oxygen tension of less than 60 Torr at rest.

104.05 *Cardiac arrhythmia, such as persistent or recurrent heart block or A-V dissociation (with or without therapy).* And one of the following:

A. Cardiac syncope; or

B. Congestive heart failure as described under the criteria in 104.02; or

C. Exercise intolerance with labored respirations on mild exertion (e.g., in infants, feeding).

104.07 *Cardiac syncope* with at least one documented syncopal episode characteristic of specific cardiac disease (e.g., aortic stenosis).

104.08 *Recurrent hemoptysis.* Associated with either pulmonary hypertension or extensive bronchial collaterals due to documented chronic cardiovascular disease.

104.09 *Chronic rheumatic fever or rheumatic heart disease.* With:

A. Persistence of rheumatic fever activity for 6 months or more, with significant murmur(s), cardiomegaly (see 104.00C), and other abnormal laboratory findings (such as elevated sedimentation rate or electrocardiographic findings); or

B. Congestive heart failure as described under the criteria in 104.02.

105.00 DIGESTIVE SYSTEM

A. *Disorders of the digestive system* which result in disability usually do so because of interference with nutrition and growth, multiple recurrent inflammatory lesions, or other complications of the disease. Such lesions or complications usually respond to treatment. To constitute a listed impairment, these must be shown to have persisted or be expected to persist despite prescribed therapy for a continuous period of at least 12 months.

B. *Documentation of gastrointestinal impairments* should include pertinent operative findings, radiographic studies, endoscopy, and biopsy reports. Where a liver biopsy has been performed in chronic liver disease, documentation should include the report of the biopsy.

C. *Growth retardation and malnutrition.* When the primary disorder of the digestive tract has been documented, evaluate resultant malnutrition under the criteria described in 105.08. Evaluate resultant growth impairment under the criteria described in 100.03. Intestinal disorders, including surgical diversions and potentially correctable congenital lesions, do not represent a severe impairment if the individual is able to maintain adequate nutrition growth and development.

D. *Multiple congenital anomalies.* See related criteria, and consider as a combination of impairments.

105.01 *Category of Impairments.* Digestive

105.03 *Esophageal obstruction, caused by atresia, stricture, or stenosis* with malnutrition as described under the criteria in 105.08.

105.05 *Chronic liver disease.* With one of the following:

A. Inoperable biliary atresia demonstrated by X-ray or surgery; or

B. Intractable ascites not attributable to other causes, with serum albumin of 3.0 gm./100 ml. or less; or

C. Esophageal varices (demonstrated by angiography, barium swallow, or endoscopy or by prior performance of a specific shunt or plication procedure); or

D. Hepatic coma documented by findings from hospital records; or

E. Hepatic encephalopathy. Evaluate under the criteria in 112.02; or

F. Chronic active inflammation or necrosis documented by SGOT persistently more than 100 units or serum bilirubin of 2.5 mg. percent or greater.

105.07 *Chronic inflammatory bowel disease (such as ulcerative colitis, regional enteritis), as documented in 105.00.* With one of the following:

A. Intestinal manifestations or complications, such as obstruction, abscess, or fistula formation which has lasted or is expected to last 12 months; or

B. Malnutrition as described under the criteria in 105.08; or

C. Growth impairment as described under the criteria in 100.03.

105.08 *Malnutrition, due to demonstrable gastrointestinal disease causing either a fall of 15 percentiles of weight which persist or the persistence of weight*

which is less than the third percentile (on standard growth charts). And one of the following:

- A. Stool fat excretion per 24 hours:
 - 1. More than 15 percent in infants less than 6 months.
 - 2. More than 10 percent in infants 6-18 months.
 - 3. More than 6 percent in children more than 18 months; or
- B. Persistent hematocrit of 30 percent or less despite prescribed therapy; or
- C. Serum carotene of 40 mcg./100 ml. or less; or
- D. Serum albumin of 3.0 gm./100 ml. or less.

106.00 GENITO-URINARY SYSTEM

A. *Determination of the presence of chronic renal disease* will be based upon the following factors:

- 1. History, physical examination, and laboratory evidence of renal disease.
- 2. Indications of its progressive nature or laboratory evidence of deterioration of renal function.

B. *Renal transplant.* The amount of function restored and the time required to effect improvement depend upon various factors including adequacy of post transplant renal function, incidence of renal infection, occurrence of rejection crisis, presence of systemic complications (anemia, neuropathy, etc.) and side effects of corticosteroid or immuno-suppressive agents. A period of at least 12 months is required for the individual to reach a point of stable medical improvement.

C. Evaluate associated disorders and complications according to the appropriate body system listing.

106.01 Category of Impairments, Genito-Urinary.

106.02 *Chronic renal disease.* With:

A. Persistent elevation of serum creatinine to 3 mg. per deciliter (100 ml.) or greater over at least 3 months; or

B. Reduction of creatinine clearance to 30 ml. per minute (43 liters/24 hours) per 1.73m² of body surface area over at least 3 months; or

C. Chronic renal dialysis program for irreversible renal failure; or

D. Renal transplant. Consider under a disability for 12 months following surgery; thereafter, evaluate the residual impairment (see 106.00B).

106.06 Nephrotic syndrome, with edema not controlled by prescribed therapy. And:

- A. Serum albumin less than 2 gm./100 ml.; or
- B. Proteinuria more than 2.5 gm./1.73m²/day.

107.00 HEMIC AND LYMPHATIC SYSTEM

A. *Sickle cell disease* refers to a chronic hemolytic anemia associated with sickle cell hemoglobin, either homozygous or in combination with thalassemia or with another abnormal hemoglobin (such as C or F).

Appropriate hematologic evidence for sickle cell diseases, such as hemoglobin electrophoresis must be included. Vaso-occlusive, hemolytic, or aplastic episodes should be documented by description of severity, frequency, and duration.

Disability due to sickle cell disease may be solely the result of a severe, persistent anemia or may be due to the combination of chronic progressive or episodic manifestations in the presence of a less severe anemia.

Major visceral episodes causing disability include meningitis, osteomyelitis, pulmonary infections or infarctions, cerebrovascular accidents, congestive heart failure, genitourinary involvement, etc.

B. *Coagulation defects.* Chronic inherited coagulation disorders must be documented by appropriate laboratory

evidence such as abnormal thromboplastin generation, coagulation time, or factor assay.

C. *Acute leukemia*. Initial diagnosis of acute leukemia must be based upon definitive bone marrow pathologic evidence. Recurrent disease may be documented by peripheral blood, bone marrow, or cerebrospinal fluid examination. The pathology report must be included.

The designated duration of disability implicit in the finding of a listed impairment is contained in 107.11. Following the designated time period, a documented diagnosis itself is no longer sufficient to establish a severe impairment. The severity of any remaining impairment must be evaluated on the basis of the medical evidence.

107.01 Category of Impairments, Hemic and Lymphatic

107.03 *Hemolytic anemia (due to any cause)*. Manifested by persistence of hematocrit of 26 percent or less despite prescribed therapy, reticulocyte count of 4 percent or greater.

107.05 *Sickle cell disease*. With:

A. Recent, recurrent, severe vaso-occlusive crises (musculoskeletal, vertebral, abdominal); or

B. A major visceral complication in the 12 months prior to application; or

C. A hyperhemolytic or aplastic crisis within 12 months prior to application; or

D. Chronic, severe anemia with persistence of hematocrit of 26 percent or less; or

E. Congestive heart failure, cerebrovascular damage, or emotional disorder as described under the criteria in 104.02, 111.00ff, or 112.00ff.

107.06 *Chronic idiopathic thrombocytopenic purpura of childhood* with purpura and thrombocytopenia of 40,000 platelets/cu. mm. or less despite prescribed therapy or recurrent upon withdrawal of treatment.

107.08 *Inherited coagulation disorder*.

With:

A. Repeated spontaneous in inappropriate bleeding; or

B. Hemarthrosis with joint deformity.

107.11 *Acute leukemia*. Consider under a disability:

A. For 2½ years from the time of initial diagnosis; or

B. For 2½ years from the time of recurrence of active disease.

108.00 [RESERVED]

109.00 ENDOCRINE SYSTEM

A. *Cause of disability*. Disability is caused by a disturbance in the regulation of the secretion or metabolism of one or more hormones which are not adequately controlled by therapy. Such disturbances or abnormalities usually respond to treatment. To constitute a listed impairment these must be shown to have persisted or be expected to persist despite prescribed therapy for a continuous period of at least 12 months.

B. *Growth*. Normal growth is usually a sensitive indicator of health as well as of adequate therapy in children. Impairment of growth may be disabling in itself or may be an indicator of a severe disorder involving the endocrine system or other body systems. Where involvement of other organ systems has occurred as a result of a primary endocrine disorder, these impairments should be evaluated according to the criteria under the appropriate sections.

C. *Documentation*. Description of characteristic history, physical findings, and diagnostic laboratory data must be included. Results of laboratory tests will be considered abnormal if outside the normal range or greater than two standard deviations from the mean of the testing

laboratory. Reports in the file should contain the information provided by the testing laboratory as to their normal values for that test.

D. *Hyperfunction of the adrenal cortex.* Evidence of growth retardation must be documented as described in 100.00. Elevated blood or urinary free cortisol levels are not acceptable in lieu of urinary 17-hydroxycorticosteroid excretion for the diagnosis of adrenal cortical hyperfunction.

E. *Adrenal cortical insufficiency.* Documentation must include persistent low plasma cortisol or low urinary 17-hydroxycorticosteroids or 17-ketogenic steroids and evidence of unresponsiveness to ACTH stimulation.

109.01 Category of Impairments, Endocrine [sic]

109.02 *Thyroid Disorders.*

A. *Hyperthyroidism* (as documented in 109.00C). With clinical manifestations despite prescribed therapy, and one of the following:

1. Elevated serum thyroxine (T_4) and either elevated free T_4 or resin T_3 uptake; or
2. Elevated thyroid uptake of radioiodine; or
3. Elevated serum triiodothyronine (T_3).

B. *Hypothyroidism.* With one of the following, despite prescribed therapy:

1. IQ of 69 or less; or
2. Growth impairment as described under the criteria in 100.02 A and B; or
3. Precocious puberty.

109.03 *Hyperparathyroidism* (as documented in 109.00C). With:

A. Repeated elevated total or ionized serum calcium; or

B. Elevated serum parathyroid hormone.

109.04 *Hypoparathyroidism or Pseudohypoparathyroidism.* With:

A. Severe recurrent tetany or convulsions which are unresponsive to prescribed therapy; or

B. Growth retardation as described under criteria in 100.02 A and B.

109.05 *Diabetes insipidus, documented by pathologic hypertonic saline or water deprivation test.* And one of the following:

A. Intracranial space-occupying lesion, before or after surgery; or

B. Unresponsiveness to Pitressin; or

C. Growth retardation as described under the criteria in 100.02 A and B; or

D. Unresponsive hypothalamic thirst center, with chronic or recurrent hypernatremia; or

E. Decreased visual fields attributable to a pituitary lesion.

109.06 *Hyperfunction of the adrenal cortex (Primary or secondary).* With:

A. Elevated urinary 17-hydroxycortico-steroids (or 17-ketogenic steroids) as documented in 109.00 C and D; and

B. Unresponsiveness to low-dose dexamethasone suppression.

109.07 *Adrenal cortical insufficiency* (as documented in 109.00 C and E) with recent, recurrent episodes of circulatory collapse.

109.08 *Juvenile diabetes mellitus* (as documented in 109.00C) requiring parenteral insulin. And one of the following, despite prescribed therapy:

A. Recent, recurrent hospitalizations with acidosis; or

B. Recent, recurrent episodes of hypoglycemia; or

C. Growth retardation as described under the criteria in 100.02 A or B; or

D. Impaired renal function as described under the criteria in 106.00ff.

109.09 Iatrogenic hypercorticot state.

With chronic glucocorticoid therapy resulting in one of the following:

- A. Osteoporosis; or
- B. Growth retardation as described under the criteria in 100.02 A or B; or
- C. Diabetes mellitus as described under the criteria in 109.08; or
- D. Myopathy as described under the criteria in 111.06; or
- E. Emotional disorder as described under the criteria in 112.00ff.

109.10 Pituitary dwarfism (with documented growth hormone deficiency). And growth impairment as described under the criteria in 100.02B.

109.11 Adrenogenital syndrome. With:

- A. Recent, recurrent self-losing episodes despite prescribed therapy; or
- B. Inadequate replacement therapy manifested by accelerated bone age and virilization, or
- C. Growth impairment as described under the criteria in 100.02 A or B.

109.12 Hypoglycemia (as documented in 109.00C). With recent, recurrent hypoglycemic episodes producing convulsion or coma.

109.13 Gonadal Dysgenesis (Turner's Syndrome), chromosomally proven. Evaluate the resulting impairment under the criteria for the appropriate body system.

110.00 MULTIPLE BODY SYSTEMS

A. *Catastrophic congenital abnormalities or disease.* This section refers only to very serious congenital disorders, diagnosed in the newborn or infant child.

B. *Immune deficiency diseases.* Documentation of immune deficiency disease must be submitted, and may in-

clude quantitative immunoglobulins, skin tests for delayed hypersensitivity, lymphocyte stimulative tests, and measurements of cellular immunity mediators.

110.01 Category of Impairments, Multiple Body Systems

110.08 Catastrophic congenital abnormalities or disease. With:

- A. A positive diagnosis (such as anencephaly, trisomy D or E, cyclopia, etc.), generally regarded as being incompatible with extrauterine life; or
- B. A positive diagnosis (such as cri du chat, Tay-Sachs Disease) wherein attainment of the growth and development level of 2 years is not expected to occur.

110.09 Immune deficiency disease.

A. *Hypogammaglobulinemia or dysgammaglobulinemia.* With:

- 1. Recent, recurrent severe infections; or
- 2. A complication such as growth retardation, chronic lung disease, collagen disorder, or tumors.

E. *Thymic dysplastic syndromes* (such as Swiss, diGeorge).

111.00 NEUROLOGICAL

A. *Seizure disorder* must be substantiated by at least one detailed description of a typical seizure. Report of recent documentation should include an electroencephalogram and neurological examination. Sleep EEG is preferable, especially with temporal lobe seizures. Frequently of attacks and any associated phenomena should also be substantiated.

Young children may have convulsions in association with febrile illnesses. Proper use of 111.02 and 111.03 requires that a seizure disorder be established. Although this does not exclude consideration of seizures occurring dur-

ing febrile illnesses, it does require documentation of seizures during nonfebrile periods.

There is an expected delay in control of seizures when treatment is started, particularly when changes in the treatment regimen are necessary. Therefore, a seizure disorder should not be considered to meet the requirements of 111.02 or 111.03 unless it is shown that seizure have persisted more than three months after prescribed therapy began.

B. *Minor motor seizures.* Classical petit mal seizures must be documented by characteristic EEG pattern, plus information as to age at onset and frequency of clinical seizures. Myoclonic seizures, whether of the typical infantile or Lennox-gastaut variety after infancy, must also be documented by the characteristic EEG pattern plus information as to age at onset and frequency of seizures.

C. *Motor dysfunction.* As described in 111.06, motor dysfunction may be due to any neurological disorder. It may be due to static or progressive conditions involving any area of the nervous system and producing any type of neurological impairment. This may include weakness, spasticity, lack of coordination, ataxia, tremor, athetosis, or sensory loss. Documentation of motor dysfunction must include neurologic findings and description of type of neurological abnormality (e.g., spasticity, weakness), as well as a description of the child's functional impairment (i.e., what the child is unable to do because of the abnormality). Where a diagnosis has been made, evidence should be included for substantiation of the diagnosis (e.g., blood chemistries and muscle biopsy reports), whenever applicable.

D. *Impairment of communications.* The documentation should include a description of a recent comprehensive evaluation, including all areas of affective and effec-

tive communication, performed by a qualified professional.

111.01 Category of Impairment, Neurological

111.02 *Major motor seizure disorder.*

A. *Major motor seizures.* In a child with an established seizure disorder, the occurrence of more than one major motor seizure per month despite at least three months of prescribed treatment. With:

1. Daytime episodes (loss of consciousness and convulsive seizures); or
2. Nocturnal episodes manifesting residuals which interfere with activity during the day.

B. *Major motor seizures.* In a child with an established seizure disorder, the occurrence of a [sic] least one major motor seizure in the year prior to application despite at least three months of prescribed treatment. And one of the following:

1. IQ of 69 or less; or
2. Significant interference with communication due to speech, hearing, or visual defect; or
3. Significant emotional disorder; or
4. Where significant adverse effects of medication interfere with major daily activities.

111.03 *Minor motor seizure disorder.* In a child with an established seizure disorder, the occurrence of more than one minor motor seizure per week, with alteration of awareness or loss of consciousness, despite at least three months of prescribed treatment.

111.05 *Brain tumors.* A. *Malignant gliomas* (astrocytoma—Grades III and IV, glioblastoma multiforme), medulloblastoma, ependymoblastoma, primary sarcoma or brain stem gliomas; or

B. Evaluate other brain tumors under the criteria for the resulting neurological impairment.

111.06 *Motor dysfunction (due to any neurological disorder)*. Persistent disorganization or deficit of motor function for age involving two extremities, which (despite prescribed therapy) interferes with age-appropriate major daily activities and results in disruption of:

- A. Fine and gross movements; or
- B. Gait and station.

111.07 *Cerebral palsy*. With:

A. Motor dysfunction meeting the requirements of 111.06 or 101.03; or

B. Less severe motor dysfunction (but more than slight) and one of the following:

- 1. IQ of 69 or less; or
- 2. Seizure disorder, with at least one major motor seizure in the year prior to application; or
- 3. Significant interference with communication due to speech, hearing or visual defect; or
- 4. Significant emotional disorder.

111.08 *Meningomyelocele (and related disorders)*. with one of the following despite prescribed treatment:

A. Motor dysfunction meeting the requirements of § 101.03 or § 111.06; or

B. Less severe motor dysfunction (but more than slight), and:

- 1. Urinary or fecal incontinence when inappropriate for age; or
- 2. IQ of 69 or less; or

C. Four extremity involvement; or

D. Noncompensated hydrocephalus producing interference with mental or motor developmental progression.

111.09 *Communication impairment, associated with documented neurological disorder*. And one of the following:

A. Documented speech deficit which significantly affects the clarity and content of the speech; or

B. Documented comprehension deficit resulting in ineffective verbal communication for age; or

C. Impairment of hearing as described under the criteria in 102.08.

112.00 MENTAL AND EMOTIONAL DISORDERS

A. *Introduction*. This section is intended primarily to describe mental and emotional disorders of young children. The criteria describing mentally determinable impairments in adults should be used where they clearly appear to be more appropriate.

B. *Mental retardation. General*. As with any other impairment, the necessary evidence consists of symptoms, signs, and laboratory findings which provide medically demonstrable evidence of impairment severity. Standardized intelligence test results are essential to the adjudication of all cases of mental retardation that are not clearly covered under the provisions of 112.05 A. Developmental milestone criteria may be the sole basis for adjudication only in cases where the child's young age and/or condition preclude formal standardized testing by a psychologist or psychiatrist experienced in testing children.

Measures of intellectual functioning. Standardized intelligence tests, such as the Wechsler Preschool and Primary Scale of Intelligence (WPPSI), the Wechsler Intelligence Scale for Children—Revised (WISC-R), the Revised Stanford-Binet Scale, and the McCarthy Scales of Children's Abilities, should be used wherever possible. Key data such as subtest scores should also be included in the report. Tests should be administered by a qualified and experienced psychologist or psychiatrist, and any discrepancies between formal test results and the child's

customary behavior and daily activities should be duly noted and resolved.

Developmental milestone criteria. In the event that a child's young age and/or condition preclude formal testing by a psychologist or psychiatrist experienced in testing children, a comprehensive evaluation covering the full range of developmental activities should be performed. This should consist of a detailed account of the child's daily activities together with direct observations by a professional person; the latter should include indices or manifestations of social, intellectual, adaptive, verbal, motor (posture, locomotion, manipulation), language, emotional, and self-care development for age. The above should then be related by the evaluating or treating physician to establish developmental norms of the kind found in any widely used standard pediatrics text.

c. *Profound combined mental-neurological-musculoskeletal impairments.* There are children with profound and irreversible brain damage resulting in total incapacitation. Such children may meet criteria in either neurological, musculoskeletal, and/or mental sections; they should be adjudicated under the criteria most completely substantiated by the medical evidence submitted. Frequently, the most appropriate criteria will be found under the mental impairment section.

112.01 Category of Impairments, Mental and Emotional

112.02 *Chronic brain syndrome.* With arrest of developmental progression for at least six months or loss of previously acquired abilities.

112.03 *Psychosis of infancy and childhood.* Documented by psychiatric evaluation and supported, if necessary, by the results of appropriate standardized psychological tests and manifested by marked restriction in the performance of daily age-appropriate activities;

constriction of age-appropriate interests; deficiency of age-appropriate self-care skills; and impaired ability to relate to others; together with persistence of one (or more) of the following:

- A. Significant withdrawal or detachment; or
- B. Impaired sense of reality; or
- C. Bizarre behavior patterns; or
- D. Strong need for maintenance of sameness, with intense anxiety, fear, or anger when change is introduced; or
- E. Panic at threat of separation from parent.

112.04 *Functional nonpsychotic disorders.* Documented by psychiatric evaluation and supported, if necessary, by the results of appropriate standardized psychological tests and manifested by marked restriction in the performance of daily age-appropriate activities; constriction of age-appropriate interests; deficiency of age-appropriate self-care skills; and impaired ability to relate to others; together with persistence of one (or more) of the following:

- A. Psychophysiological disorder (e.g., diarrhea, asthma); or
- B. Anxiety; or
- C. Depression; or
- D. Phobic, obsessive, or compulsive behavior; or
- E. Hypochondriasis; or
- F. Hysteria; or
- G. Asocial or antisocial behavior.

112.05 *Mental retardation.*

A. Achievement of only those developmental milestones generally acquired by children no more than one-half of the child's chronological age; or

- B. IQ of 59 or less; or
- C. IQ of 60-69, inclusive, and a physical or other mental impairment imposing additional and significant restriction of function or developmental progression.

113.00 NEOPLASTIC DISEASES, MALIGNANT

A. *Introduction.* Determination of disability in the growing and developing child with a malignant neoplastic disease as based upon the combined effects of:

1. The pathophysiology, histology, and natural history of the tumor; and
2. The effects of the currently employed aggressive multimodal therapeutic regimens.

Combinations of surgery, radiation, and chemotherapy or prolonged therapeutic schedules impart significant additional morbidity to the child during the period of greatest risk from the tumor itself. This period of highest risk and greatest therapeutically-induced morbidity defines the limits of disability for most of childhood neoplastic disease.

B. *Documentation.* The diagnosis of neoplasm should be established on the basis of symptoms, signs, and laboratory findings. The site of the primary, recurrent, and metastatic lesion must be specified in all cases of malignant neoplastic diseases. If an operative procedure has been performed, the evidence should include a copy of the operative note and the report of the gross and microscopic examination of the surgical specimen, along with all pertinent laboratory and X-ray reports. The evidence should also include a recent report directed especially at describing whether there is evidence of local or regional recurrence, soft part or skeletal metastases, and significant post therapeutic residuals.

C. *Malignant solid tumors*, as listed under 113.03, include the histiocytosis syndromes except for solitary eosinophilic granuloma. Thus, 113.03 should not be used for evaluating brain tumors (see 111.05) or thyroid tumors, which must be evaluated on the basis of whether they are controlled by prescribed therapy.

D. *Duration of disability* from malignant neoplastic tumors is included in 113.02 and 113.03. Following the time periods designated in these sections, a documented diagnosis itself is no longer sufficient to establish a severe impairment. The severity of a remaining impairment must be evaluated on the basis of the medical evidence.

113.01 Category of Impairments, Neoplastic Diseases—Malignant

113.02 *Lymphoreticular malignant neoplasms.*

A. Hodgkin's disease with progressive disease not controlled by prescribed therapy; or

B. Non-Hodgkin's lymphoma. Consider under a disability:

1. For 2½ years from time of initial diagnosis; or
2. For 2½ years from time of recurrence of active disease.

113.03 *Malignant solid tumors.* Consider under a disability:

- A. For 2 years from the time of initial diagnosis; or
- B. For 2 years from the time of recurrence of active disease.

113.04 *Neuroblastoma.* With one of the following:

- A. Extension across the midline; or
- B. Distant metastases; or
- C. Recurrence; or
- D. Onset at age 1 year or older.

113.05 *Retinoblastoma.* With one of the following:

- A. Bilateral involvement; or
- B. Metastases; or
- C. Extension beyond the orbit; or
- D. Recurrence.

[50 FR 35066, Aug. 28, 1985; 50 FR 38113, Sept. 20, 1985, and 50 FR 50088, Dec. 6, 1985; 51 FR 5989, Feb. 19, 1986; 51 FR 7933, Mar. 7, 1986; 51 FR 16016, Apr. 30, 1986]

Social Security Ruling (SSR) 83-19
(West's Social Security Reporting Service)
(Rulings Supp. Pamph. 1988)

**TITLES II AND XVI: FINDING DISABILITY
 ON THE BASIS OF MEDICAL CONSIDERATIONS ALONE—
 THE LISTING OF IMPAIRMENTS AND MEDICAL
 EQUIVALENCY**

PURPOSE: To state the policy and describe the criteria for a finding of disability under titles II and XVI of the Social Security Act based on impairments which meet or equal the Listing of Impairments.

CITATIONS (AUTHORITY): Sections 216(i), 223(d) and 1614(a) of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections 404.1505, 404.1508, 404.1513, 404.1520(d), 404.1525, 404.1526, 404.1528, 404.1529, 404.1577, 404.1578; and Regulations No. 16, Subpart I, sections 416.905, 416.906, 416.908, 416.913, 416.920(d), 416.923, 416.925, 416.926 and 416.928; Regulations No. 4, Subpart P, Appendix 1, Listing of Impairments.

INTRODUCTION: A finding of disability on medical grounds alone is made when the individual's medical condition is one which meets the specific criteria in the Listing of Impairments (the listing) or is the equivalent of a listed impairment. The criteria in the listing provide the basic frame of reference for the medical evaluation of all disability claims.

The listing contains over 100 examples of medical conditions which ordinarily prevent an individual from engaging in any gainful activity. The listing permits adjudicators to quickly and readily identify those persons who clearly have disabling impairments.

Impairments manifestations are so numerous and varied that it is difficult to include in the listing all the sets of medical findings which describe impairments severe enough to prevent any gainful work. When the individual does not have any impairment specifically described in the listing, a physician designated by the Secretary of the Department of Health and Human Services is called upon to provide an expert medical judgment as to whether the set of symptoms, signs, and laboratory findings of the individual's impairment(s) is equivalent to one of the sets of symptoms, signs, and laboratory findings contained in the listing. If the individual's impairment(s) has the specific medical findings of a listed set of medical findings or findings that are equal in severity and duration to a set of listed findings, the individual is considered to be unable to engage in any gainful activity and, thus, can be found disabled on medical grounds alone.

POLICY STATEMENT: Under the Listing of Impairments, the severity of each listed impairment generally precludes the effective performance of any gainful work activity. If an individual has a medical condition with the specific medical findings described in the listing or one that is the medical equivalent of any listed set of findings (and meets the 12-month duration requirement), a finding of disability will be made in the absence of evidence to the contrary (i.e., performance of substantial gainful activity or failure without a good reason to follow prescribed treatment which is expected to restore the capacity to work).

Under the concept of medical equivalence, a physician designated by the Secretary is required to decide whether the medical findings of an individual's impairment(s), although not specifically described by any listed set of medical criteria in the listing, are at least medically equivalent to one of the listed sets.

Impairments That Meet the Listing

An impairment "meets" a listed condition in the Listing of Impairments only when it manifests the specific findings described in the set of medical criteria for that listed impairment. A finding that an impairment meets the listing will not be justified on the basis of a diagnosis alone.

The "level of severity" of impairments in the listing is not defined in terms of the residual functional capacity (RFC) of the individual. When certain functional limitations are specified for a listed impairment, they relate only to the degree of dysfunction for that particular listing section and only to the specific function identified. For example, Listing 1.10C (inability to use a prosthesis effectively, without obligatory assistive devices), relates *only* to the underlying medical disorder which prohibits the use of a prosthesis and does not *directly* relate to the standing and walking requirements described for the levels of physical exertion in the PPS-102, SSR 83-11, Titles II and XVI: Capability to Do Other Work—The Exertionally Based Medical-Vocational Rules Met.

Impairments That Equal a Listed Impairment

To determine whether an impairment or a combination of impairments is of severity equivalent to a listed impairment, the set of symptoms, signs, and laboratory findings in the medical evidence supporting a claim must be compared with the set of symptoms, signs, and laboratory findings specified for the listed impairment most like the individual's impairment(s). The impairment(s) may be judged to be equivalent to a listed impairment only if the medical findings (defined as a set of symptoms, signs, and laboratory findings) are at least equivalent in severity to

the set of medical findings for the listed impairment. In no instance will symptoms alone justify a finding of equivalence. (See PPS-82, SSR 82-58, Titles II and XVI: Evaluation of Symptoms.)

Equivalency can be found under three circumstances:

1. A *listed* impairment for which one or more of the specified medical findings is missing from the evidence but for which other medical findings of equal or greater clinical significance and relating to the same impairment are present in the medical evidence.
2. An *unlisted* impairment, in which the set of criteria for the most closely analogous listed impairment is used for comparison with the findings of the unlisted impairment.
3. A *combination of impairments* (none of which meet or equal a listed impairment), each manifested by a set of symptoms, signs, and laboratory findings which, combined, are determined to be medically equivalent in medical severity to that listed set to which the combined sets can be most closely related.

Medical equivalence may not be established when the reported medical findings reflect lesser severity than listed criteria require (and there are no related findings of equal or greater medical significance).

As in determining whether the listing is met, it is incorrect to consider whether the listing is equaled on the basis of an assessment of overall functional impairment. The level of severity in any particular listing section is depicted by the *given set* of findings and not by the degree of severity of any single medical finding—no matter to what extent that finding may exceed the listed value.

The mere accumulation of a number of impairments also will not establish medical equivalence. When an individual suffers from a combination of untreated impairments, the medical findings of the combined impairments will be compared to the findings of the listed impairment most similar to the individual's most severe impairment. The functional consequences of the impairments (i.e., RFC), irrespective of their nature or extent, *cannot* justify a determination of equivalence.

Any decision that an individual's impairment(s) is medically the equivalent of a listed impairment must be based on findings demonstrated by medically acceptable clinical and laboratory diagnostic techniques. Decisions of equivalence are the responsibility of a physician designated by the Secretary. In most instances, the designated physician is a physician in the State agency. A medical advisor at a hearing or a member of the Appeals Council's (AC) medical support staff (including medical consultants) may also make the physician's decision in the determination of medical equivalence.

As with any other medical opinion concerning impairment severity for titles II and XVI disability purposes, judgments of the examining physician are not controlling on the issue of equivalence. In every instance, the decision as to equivalence is to be made by a program physician based upon the individual medical findings in the particular case.

Hearings and Appeals

By comparing the clinical signs, symptoms, and laboratory findings from the evidence of record with those in the listing, the administrative law judge (ALJ) can usually readily determine whether the listing is met. By

contrast, a determination that an impairment or combination of impairments is *equal* to a listed impairment requires greater medical expertise. It must be determined whether the medical findings in the record are of at least equivalent *clinical significance* to the findings required in the listing.

At the initial and reconsideration levels, the signature of the State agency staff physician on the SSA-831-U5/SSA-833-U5 serves as the basis for the determination and assures that consideration by a physician designated by the Secretary has been given to the question of medical equivalence. At the hearing level, the ALJ is responsible for deciding the ultimate legal question of whether the listing is met or equaled. As trier of the facts, the ALJ is not *bound* by the medical judgment of a "designated" physician regarding medical equivalency. However, the judgment of a "designated" physician on this issue on the same evidence before the ALJ must be received into the record as expert opinion evidence and given appropriate weight. Furthermore, to assure that proper consideration is given to a medical equivalency opinion from a physician designated by the Secretary, the ALJ must obtain an updated medical judgment from a medical advisor (interrogatories may be used) in the following circumstances:

1. When no additional medical evidence is received, but, in the opinion of the ALJ, the symptoms, signs, and laboratory findings reported in the record suggest that a judgment of equivalency may be reasonable.
2. When additional medical evidence is received which, in the opinion of the ALJ, may change the determination of the SSA-831-U5/SSA-833-U5 that the impairment(s) does not equal the listing.

When an updated medical judgment as to medical equivalency is required at the AC level, the AC must call on the services of its medical support staff (including medical consultants).

The Disability Determination or Decision

PPS-81, SSR 82-56, Titles II and XVI: The Sequential Evaluation Process, discuss the role of the listing in the evaluation process (see also the following section) and also provides some detail about the format and contents of the disability determination or decision. The rationale in the determination or decision must reflect consideration of the pertinent evidence of record and reconcile or resolve significant inconsistencies. When a favorable determination or decision is based on the listing being met or equaled, the *particular* listed impairment which is applicable to the case must be cited, together with the medical findings that meet or equal the listed impairment criteria.

Types of Claims Allowable Only on the Basis of Medical Factors

Title II: Disabled Widow, Widower, or Surviving Divorced Spouse

Regulation section 404.1577 provides that a widow, widower, or surviving divorced spouse must have a medically determinable impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of no less than 12 months. The impairment must be of a level of severity to prevent a person from doing any gainful activity. Regulation section 404.1578 provides that the impairment(s) must have specific medical findings that meet or equal those of any impairment in the Listing of Impairments. Therefore, only

the medical impairment is to be considered and age, education, and work experience are specifically excluded.

Title XVI: Children Under Age 18

Under Regulations sections 416.906 and 416.923, a child under age 18 will be considered disabled if he or she: (a) has a medically determinable impairment which compares in severity to an impairment which would make an adult disabled on the basis of medical evidence alone and (b) is not performing any SGA.

Part B of the Listing of Impairments presents sets of impairment criteria which are particularly applicable to children under age 18 and, consequently, should be considered first. However, when the criteria of part B do not effectively address a child's impairment, the medical criteria in part A may be applied to the evaluation of impairments in persons under age 18 when the disease processes involved have a similar effect upon *both* adults and younger persons. To establish childhood disability, the impairment *must* meet or equal a specific listed set of criteria in either part A or part B of the listing.

EFFECTIVE DATE: The policy explained herein was effective August 20, 1980, the date the regulations covering the basic policy in the subject area were effective (45 FR 55566).

SOCIAL SECURITY ADMINISTRATION
Program Operation Manual System (POMS)
(Disability Insurance (DI))

Medical Evaluation

**Residual Functional Capacity
(RFC)**

References: (CFR 404.1545-1546 and 416.945-.946)

24510.001 GENERAL

Residual functional capacity (RFC) is the remaining capacity to perform work related physical and mental activities despite functional limitations resulting from medically determinable impairments. This concept along with other factors affecting an individual's vocational adjustment (i.e., age, education, and work history) is a factor in those steps in sequential evaluation involving an assessment of ability to do past relevant work or other work.

An RFC assessment must be fully documented to support adjudicative conclusions of what an individual can still do in a work setting, and must be fully responsive to the claimant's statements, including those about symptoms (especially pain) which concern the nature and extent of the impairments.

RFC assessment is the responsibility of the DDS medical consultant and is based primarily on medical findings which must be complete enough to permit and support the necessary judgments concerning the individual's physical, mental, and sensory capacities, and any environmental restrictions. This should include appropriate history, signs, symptoms, clinical and laboratory findings for full documentation.

In addition to formal medical evaluation, such as consultative consultative examinations, test results, descriptions and observations of the claimant's restrictions by both medical and nonmedical sources must be considered in determining an RFC.

When multiple physical and/or mental impairments are involved, the RFC is derived from an assessment of the remaining functional capacity after consideration of all impairments.

The RFC assessment is expressed in terms of a person's capacities and limitations in performing work related activities. An assessment of physical capacities must reflect what an individual can do on a sustained basis.

This includes an evaluation of the capacity to perform basic strength factors such as lifting, carrying, standing, walking, sitting, and pushing or pulling. Other physical factors which must be considered include climbing, balancing, stooping, kneeling, crouching, crawling, reaching, handling, and fingering. Sensory physical factors such as feeling, seeing and hearing must also be considered as well as the capacity to speak. Environmental restrictions must be described. They include medically imposed restrictions to working around heights, machinery, temperature extremes, dust, fumes, humidity, vibrations, etc.

The RFC considerations for mental impairments include understanding and memory, sustained concentration and persistence, social interaction and adaptation. Each of these broad areas includes specific mental activities which must be addressed in determining a person's capacities and limitations to perform at a sustained level in competitive employment.

22001.020 Does the Individual Have Any Impairment(s) Which Meets or Equals the Listings?

- A. A finding of disability ordinarily will be justified when the individual's impairment is one which is as severe as the impairments contained in the Listing of Impairments. The Listing of Impairments (see Regulations No. 4, Subpart P, Appendix 1) contains over 100 medical conditions which would ordinarily prevent an individual from engaging in any gainful activity. The Listings help to assure that determinations or decisions of disability have a sound medical basis, that claimants receive equal treatment throughout the country, and that the majority of persons who are disabled can be readily identified.
- B. The level of severity described in the Listings is such that an individual who is not engaging in SGA and has an impairment or the equivalent of an impairment described therein is generally considered unable to work by reason of the medical impairment alone. Thus, when such an individual's impairment or combination of impairments meets or equals the level of severity described in the Listings, and also meets the duration requirements (DI 25505.000ff), disability will be found on the basis of the medical facts alone in the absence of evidence to the contrary (e.g., the actual performance of SGA, or failure to follow prescribed treatment without a justifiable reason). The claimant's impairment(s) must meet or equal a listed impairment for a favorable determination or decision to be based on medical consideration alone. (See DI 24505.000ff which further explains the concept of finding disability on medical basis alone.)
- C. For an impairment to be found to be equivalent in severity to a listed impairment, the set of symptoms,

- signs and laboratory findings in the medical evidence supporting a claim must be compared with and found to be equivalent in terms of medical severity and duration to the set of symptoms, signs and laboratory findings specified for a listed impairment. When the individual's impairment is not listed, the set for the most closely analogous listed impairment is used.
- D. Where an individual has a combination of impairments, none of which meets or equals a listed impairment, and each impairment is manifested by a set of symptoms and relevant signs and/or abnormal laboratory findings, the collective medical findings of the combined impairments must be matched to the specific set of symptoms, signs, and laboratory findings of the listed impairment to which they can be most closely related. The mere accumulation of a number of impairments will not establish medical equivalency. In no case are symptoms alone a sufficient basis for establishing the presence of a physical or mental impairment.
- E. Any decision as to whether an individual's impairment(s) is medically the equivalent of a listed impairment, must be based on medical evidence demonstrated by medically acceptable clinical and laboratory diagnostic techniques, including consideration of a medical judgment about medical equivalence furnished by one or more physicians designated by the Secretary. The disability determination services physician's documented medical judgment as to equivalency meets this regulatory requirement.

NOTE: *Sequential evaluation ends here for disabled widows, widowers, surviving divorced spouses, and children under age 18.*

24505.015 Finding Disability on the Basis of Medical Factors Alone

The next step in sequential evaluation is to determine if the individual has an impairment(s) which meets or is equivalent to the listings in the Listing of Impairments. The criteria in the Listing provides the basis frame of reference for the medical evaluation of all disability claims.

A. General

The Listing contains over 100 examples of medical conditions which ordinarily prevent an individual from engaging in any gainful activity. The Listing permits adjudicators to quickly and readily identify those persons who clearly have disabling impairments.

Impairment manifestations are so numerous and varied that it is difficult to include in the Listing all the sets of medical findings which describe impairments severe enough to prevent any gainful work. When the individual does not have any impairment specifically described in the Listing, a DDS medical consultant is called upon to provide an expert medical judgment as to whether the set of symptoms, signs and laboratory findings of the individual's impairment(s) is equivalent to one of the sets of symptoms, signs, and laboratory findings contained in the Listing. If the individual's impairment(s) has the specific medical findings of a listed set of medical findings or findings that are equal in severity and duration to a set of listed findings, the individual is not considered to be able to engage in any gainful activity and thus, can be found disabled on medical grounds alone.

Under the Listing of Impairments, the severity of each listed impairment generally precludes the effective performances of any gainful work activity. If an individual has a medical condition with the specific medical

findings described in the Listing or one that is the medical equivalent of any listed set of findings (and meets the 12-month's duration requirement), a finding of disability will be made in the absence of evidence to the contrary (e.g., performance of substantial gainful activity or failure without a good reason to follow prescribed treatment which is expected to restore the capacity to work).

Under the concept of medical equivalence, a DDS medical consultant is required to decide whether the medical findings of an individual's impairment(s), although not specifically described by any listed set of medical criteria in the Listing, is at least medically equivalent to one of the listed sets.

B. Impairments That Meet the Listing

An impairment "meets" a listed condition in the Listing of Impairments only when it manifests the specific findings described in the set of medical criteria for that listed impairment. A finding that an impairment meets the Listing will not be justified on the basis of a diagnosis alone.

The "level of severity" of impairments in the listing is not defined in terms of the residual functional capacity (RFC) of the individual. When certain functional limitations are specified for a listed impairment, they relate only to the degree of dysfunction for the particular listing section and only to the specific function identified.

C. Impairments That Equal a Listed Impairment

To determine whether an impairment or a combination of impairments is of severity equivalent to a listed impairment, the set of symptoms, signs, and laboratory findings in the medical evidence supporting a claim must be compared with the set of symptoms, and laboratory findings

specified for the listed impairment most like the individual's impairment(s). The impairment(s) may be judged to be equivalent to a listed impairment only if the medical findings (defined as a set of symptoms, signs, and laboratory findings) are at least equivalent in severity to the set of medical findings for the listed impairment. In no instance will symptoms alone justify a finding of equivalence. (See DI 24515.060, Evaluation of Symptoms.)

Equivalency can be found under three circumstances.

1. LISTED IMPAIRMENTS

A listed impairment for which one or more of the specified medical findings is missing from the evidence but for which other medical findings of equal or greater clinical significance and relating to the same impairment are present in the medical evidence.

2. UNLISTED IMPAIRMENTS

An unlisted impairment, in which the set of criteria for the most closely analogous listed impairment is used for comparison with the findings of the unlisted impairment.

3. MULTIPLE IMPAIRMENTS

A combination of impairments (none of which meet or equal a listed impairment), each manifested by a set of symptoms, signs and laboratory findings which, combined, are determined to be medically equivalent in medical severity to that listed set to which the combined sets can be most closely related.

Medical equivalence may not be established when the reported medical findings reflect lesser severity than listed criteria require (and there are no related findings of equal or greater medical significance).

As in determining whether the listing is met, it is incorrect to consider whether the listing is equaled on the basis of an assessment of overall functional impairment. The level of severity in any particular listing section is depicted by the given set of findings and not by the degree of severity of any single medical finding—no matter to what extent that finding may exceed the listed value.

The mere accumulation of a number of impairments also will not establish medical equivalence. When an individual suffers from a combination of unrelated impairments, the medical findings of the combined impairments will be compared to the findings of the listed impairment most similar to the individual's most severe impairment. The functional consequences of the impairments (i.e., RFC), irrespective of their future or extent, cannot justify a determination of equivalence.

Any decision that an individual's impairment(s) is medically the equivalent of a listed impairment must be based on findings demonstrated by medically acceptable clinical and laboratory diagnostic techniques. Decisions of equivalence are the responsibility of a physician designated by the Secretary. In most instances, the designated physician is a physician in the State agency. A medical advisor at a hearing or a member of the Appeals Council's (AC) medical support staff (including medical consultants) may also make the physician's decision in the determination of medical equivalence.

As with any other medical opinion concerning impairment severity for title II and the title XVI disability purposes, judgments of the examining physician, which they may be of considerable weight, are not controlling on the issue of equivalence. In every instance, the decision as to equivalence is to be made by a program physician based upon the individual medical findings in the particular case.

D. The Disability Determination or Decision

The rationale in the determination or decision must reflect consideration of the pertinent evidence of record and reconcile or resolve significant inconsistencies. When a favorable determination or decision is based on the listing being met or equaled, the particular listed impairment which is applicable to the case must be cited, together with the medical findings that meet or equal the listed impairment criteria.

E. Types of Claims Allowable Only on the Basis of Medical Factors—Title II-DWB and Title XVI-DC

1. Title II: Disabled Widow, Widower, or Surviving Divorced Spouse

CFR 404.1577 provides that a widow, widower, or surviving divorced spouse must have a medically determinable impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of no less than 12 months. The impairment must be of a level of severity to prevent a person from doing any gainful activity. Regulation section 404.1578 provides that the impairment(s) must have specific medical findings that meet or equal those of any impairment in the Listing of Impairments. Therefore, only the medical impairment is to be considered and age, education, and work experience are specifically excluded.

2. TITLE XVI: CHILDREN UNDER AGE 18

Under CFR 416.906 and 416.923, child [sic] under age 18 will be considered disabled if he or she: (a) has a medically determinable impairment which compares in severity to an impairment which would make an adult disabled on the basis of medical evidence alone and (b) is not performing any SGA.

Part B of the Listing of Impairments presents acts of impairment criteria which are particularly applicable to

children under age 18 and, consequently, should be considered first. However, when the criteria of part B do not effectively address a child's impairment, the medical criteria in part A may be applied to the evaluation of impairments in persons under age 18 when the disease processes involved have a similar effect upon both adults and younger persons. To establish childhood disability, the impairment must meet or equal a specific listed set of criteria in either part A or part B of the listing.

24501.025 Evaluation of Symptoms

A. General

Symptoms such as pain, shortness of breath, weakness, or nervousness are the individual's own perceptions of the effects of a physical or mental impairment(s). Because of their subjective characteristics and the absence of any reliable technique for measurement, symptoms (especially pain) are difficult to prove, disprove, or quantify.

Symptoms will not have a significant effect on a disability determination or decision unless medical signs or findings show that a medical condition is present that could reasonably be expected to produce the symptoms which are alleged or reported. However, once such a medical condition (e.g., disc disease) is objectively established, the symptoms are still not controlling for purposes of evaluating disability. Clinical and laboratory data and a well-documented medical history must establish findings which may reasonably account for the symptom in a particular impairment. Objective clinical findings can be used to draw reasonable conclusions about the validity of the intensity and persistence of the symptoms and about its effect on the individual's work capacity. For example, in cases of back pain associated with disc disease, typical

associated findings are muscle spasm, sensory loss, motor loss, and atrophy. There must be an objective basis to support the overall evaluation of impairment severity. It is not sufficient to merely establish a diagnosis or a source for the symptom.

When symptoms are alleged as a significant aspect of the impairment but the criteria for a listed impairment are not met or equaled and a severe impairment exists, the symptoms must be considered in evaluating disability and must be addressed in the disability determination or decision. The following sequential evaluation process facilitates that consideration.

See DI 24515.060 for evaluation of pain.

B. Need to Establish a Medically Determinable Severe Impairment

To be found disabled under the law, an individual must have a medically determinable severe impairment, i.e., an impairment which has demonstrable anatomical, physiological or psychological abnormalities. Such abnormalities are medically determinable if they manifest themselves through medical evidence consisting of symptoms, signs, and laboratory findings. Symptoms, alone, however, do not constitute a basis for finding a medically determinable impairment.

If no medically determinable *physical* impairment is found, yet the person alleges work-related limitations due to a symptom normally attributable to a physical impairment, the possibility of a medically determinable severe *medical* impairment must be considered. When a medically determinable severe impairment cannot be established on either a physical or a mental basis, the claim must be denied, regardless of the intensity of the symptom, related limitations alleged, or any judgments by examining medical sources about the effects of the symptom.

C. Decide Whether the Listing Is Met or Equaled

When a medically determinable severe impairment or combination of impairments is documented, the next step is to determine whether the Listing of Impairments is met or equaled. The Listing of Impairments includes requisite symptoms in certain circumstances. In determining whether a listed set of criteria which includes a symptom as one criterion is met, ordinarily it is essential only that the symptom(s) be present, *in combination* with the required clinical signs and laboratory findings. Unless specifically stated in the Listing, quantification or other evaluation of the degree of functionally limiting effects of that symptom is not required to determine whether the criteria is a listed impairment are met.

If the listed criteria are not met, consider whether the impairment equals a set of symptoms and findings in the Listing. However, if the requisite clinical signs and laboratory findings, or other findings of equal or greater significance are not present, the symptom cannot be persuasive that the Listing is met or equaled. *No alleged or reported intensity of the symptoms can be substituted to elevate impairment severity to equivalency.* For example, if pain is present and is a requisite for a listed impairment, but one (or more) of the requisite clinical or laboratory findings for meeting the Listing is missing or is of a lesser value, complaints of "severe," "extreme," or "constant" pain will not compensate for the missing medical findings and permit an "equals" determination.

D. Determine the Impact of Symptoms on Residual Functional Capacity

When the listed impairment criteria are not met or equaled but one or a combination of impairments is severe, an RFC assessment must be made. In assessing

symptoms such as pain as a factor of RFC, the functionally limiting effects of the symptom can play a significant role. See DI 24510.030 for impact of symptoms on RFC.

24510.030 The Impact of Symptoms on Residual Functional Capacity

When the listed impairment criteria are not met or equaled but one or more impairments are severe, an RFC assessment must be made. In assessing symptoms such as pain, as a factor of RFC, the functionally limiting effects of the symptom can play a significant role. The effects of symptoms must be considered in terms of any additional physical or mental restrictions they may impose beyond those clearly demonstrated by the objective physical manifestations of disorders. Symptoms can sometimes suggest a greater severity of impairment than is demonstrated by objective medical findings alone. However, since symptoms such as pain, are subjective and cannot be quantified by any reliable method, any additional symptom-related functional limitations must largely be inferred from the history and the objective physical findings (e.g., reduced joint motion, muscle wasting, muscle spasm, sensory and motor disruption) and from medical knowledge as to what symptom-related effects on functional capacity can be reasonably expected. In assessing allegations of disabling symptoms, consideration should be given to data such as the alleged frequency and duration of the symptom (with pain, location and radiation); precipitating or aggravating factors; effect on daily activities; and dosage, effectiveness, and side-effects of medication; as well as any recorded observations about symptoms by persons such as examining physicians and Social Security Administration employees (district office representatives, administrative law judges, etc.). Reasonable conclusions can be drawn from such informa-

tion concerning both the presence and persistence of the symptom and its effects and any resultant additional diminution of RFC.

There may be an emotional component to all symptoms, but the fact that an individual may seem to be exaggerating the limitations arising from a symptom does not necessarily mean that the symptom or the alleged functional limitation is in any way the result of an emotional disorder. However, when alleged symptom-related limitations are clearly out of proportion to physical findings (e.g., no clinical findings of severe neuromuscular disorder, yet the individual alleges inability to stand, bend, or walk due to constant pain), the *possibility* of a severe mental impairment should be investigated. Consequently, if there are unconfirmed but alleged significant functional limitations and medical evidence received from treating and examining medical sources does not resolve whether a severe mental impairment is present, we will consider obtaining a psychiatric evaluation. (See DI 24510.075 for evaluation of symptoms in mental disorder cases.)

When a severe psychiatric impairment is demonstrated, conclusions about the significance of pain, or of any other symptom of emotional origin, will be based on the determination of the severity of the mental impairment and the resultant limitation of activities, interests, personal habits, and ability to relate to others.

Thorough and comprehensive RFC assessments become most critical in denial determinations and decisions, when the persistence or the extent of alleged or reported symptom-related limitations is (1) not consistent with the severity of the physical impairment which has been established and (2) not explainable on a psychiatric basis. In those situations, it is essential to identify and resolve all conflicting medical source conclusions and claimant

allegations about functional capacity. The RFC assessment must convey the reason(s) why the alleged or reported symptom-related functional limitation is not supported by the evidence. Statements by the treating or examining sources or by the individual which are consistent with the ultimate conclusion as to functional capacity should also be included in the RFC discussion.

See DI 24515.060 for evaluation of pain.

SOCIAL SECURITY ADMINISTRATION
Program Operations Manual System (POMS) (1984)
(Disability Insurance (DI))

Case Development and Evaluation

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**00401.336 Inability To Engage In Any Gainful Activity: Title II
 Widow, Widower or Surviving Divorced Spouse/Title
 XVI Child Under Age 18**

In the Listing of Impairments, the regulations describe impairments of a level of severity deemed to preclude an individual from engaging in *any* gainful activity. An applicant for title II disabled widow's, widower's, or surviving divorced spouse's benefits or title XVI child's benefits *must* have an impairment(s) that meets or equals an impairment in the Listing.

As in the case of a title II worker or CDB applicant or a title XVI claimant age 18 or older, a title II widow(er), or title XVI child whose work demonstrates ability to engage in SGA is not under a disability. The level of severity of an impairment which a title II widow(er) or a title XVI child must meet or equal to be determined to be under a disability is that which is considered under the regulations to be sufficient to preclude engaging in *any gainful* activity (i.e., must meet or equal the Listings), as distinguished from SGA. The concept of "gainful activity," however, is used only in setting the requisite level of severity of the impairment in the Listing of Impairments and not otherwise.

In the Supreme Court of the United States

No. 88-1377

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN
SERVICES, PETITIONER

v.

BRIAN ZEBLEY, ET AL.

ORDER ALLOWING CERTIORARI. Filed May 15, 1989.

The petition herein for a writ of certiorari to the United
States Court of Appeals for the Third Circuit is granted.

MAY 15, 1989